AN ACT

To repeal sections 374.160, 375.772, 375.773, 375.774, 375.775, 375.776, 375.778, 375.779, 375.1220, 376.421, 376.424, 376.426, 376.816, 376.960, 376.966, 376.975, 376.986, 376.995, 379.110, 379.815, 379.825, 379.930, 379.938, 379.940, 379.942, 379.943, 379.952, 382.210, 384.043, 384.062, and 384.065, RSMo, and to enact in lieu thereof forty-two new sections relating to insurance, with an effective date.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF MISSOURI, AS FOLLOWS:

Section A. Sections 374.160, 375.772, 375.773, 375.774, 375.775, 375.776, 375.778, 375.779, 375.1220, 376.421, 376.424, 376.426, 376.816, 376.960, 376.966, 376.975, 376.986, 376.995, 379.110, 379.815, 379.825, 379.930, 379.938, 379.940, 379.942, 379.943, 379.952, 382.210, 384.043, 384.062, and 384.065, RSMo, are repealed and forty-two new sections enacted in lieu thereof, to be known as sections 374.160, 375.772, 375.773, 375.774, 375.775, 375.776, 375.778, 375.779, 375.1220, 376.421, 376.424, 376.426, 376.450, 376.451, 376.452, 376.771, 376.794, 376.816, 376.960, 376.966, 376.975, 376.986, 376.995, 376.1578, 376.1581, 376.1584, 376.1587, 376.1590, 376.1593, 376.1600, 379.110, 379.815, 379.825, 379.930, 379.938, 379.940, 379.943, 379.952, 382.210, 384.043, 384.062, and 384.065, to read as follows:

374.160. 1. The expenses of **[**examinations,**]** valuations or proceedings against any company, and for dissolving or settling

the affairs of companies are to be paid by the company, or as provided by law. The state shall not be responsible in any manner for the payment of any such expenses, or any charges connected therewith.

2. All other expenses of the department of insurance now or hereafter incurred and unpaid, or that may be hereafter incurred, including the salaries of the director and deputy director, shall be paid out of the state treasury in the manner provided by law.

3. The director shall assess the direct expenses incurred by examiners of any examination against the company examined and shall order that the examination expenses be paid into the insurance examiners fund created by section 374.162. Any such assessment shall include an itemized report prepared by the director or the director's designee that indicates the direct expenses incurred by the examiners. The report shall include the amount of time spent by each examiner whose expenses are included in the report and the rate of pay for each examiner. Each examiner whose direct expenses are included in the report shall complete a written form that verifies and attests to the direct expenses incurred by such examiner during the examination. The entire detailed report, including the examiners' forms described in this subsection, shall be submitted to the examined company and an appropriate representative of such company shall verify the accuracy of the report prior to any assessment against the

examined company. The director shall also assess an additional amount equal to [fifteen] five percent of the total expenses of examination, to be paid for the supervision and support of the examiners. The insurance examiner's sick leave fund created by sections 374.261 to 374.267 shall be combined with the insurance examiners fund. The director shall pay from the insurance examiners fund the compensation of insurance examiners pursuant to section 374.115[,] and any expenses to be paid from such sick leave fund under sections 374.261 to 374.267, and expenses incurred for supervision and support of the examiners. The general assembly shall annually provide appropriations sufficient to distribute all receipts into the insurance examiners fund. The provisions of section 33.080, RSMo, relating to the transfer of unexpended balances to the general revenue fund shall not apply to the insurance examiners fund.

4. If any company shall refuse to pay the expenses of any examination, valuation or proceeding assessed by the director pursuant to this section, the company shall be liable for double the amount of such expenses and all costs of collection, including attorney's fees. The company shall not be entitled to a credit, pursuant to section 148.400, RSMo, for any [fees, expenses or] costs ordered pursuant to this subsection other than in the amount of the expenses originally assessed by the director. All amounts collected pursuant to this subsection

shall be credited to the insurance examiners fund.

5. Each employee or other authorized agent of the department of insurance may be provided a per diem for expenses or be reimbursed for actual expenses incurred by such employee or agent, or may receive the amount provided for members of the general assembly pursuant to section 21.145, RSMo, whichever is less. A company shall only be assessed examination expenses for employee or agent expenses, including travel reimbursement, pursuant to subsection 3 of this section in amounts prescribed in this subsection.

375.772. 1. There is created a nonprofit unincorporated legal entity to be known as the "Missouri Property and Casualty Insurance Guaranty Association", hereinafter referred to as "association". All member insurers shall be and remain members of the association as a condition of their authority to transact insurance in this state. The association shall perform its functions under a plan of operation and through a board of directors established by section 375.776.

2. As used in sections 375.771 to 375.779, the following terms mean:

(1) "Account", any one of the four accounts established by section 375.773;

(2) "Affiliate", a person who directly or indirectly through one or more intermediaries controls, is controlled by, or

is under common control with another person;

(3) "Affiliate of an insolvent insurer", a person who directly or indirectly through one or more intermediaries controls, is controlled by, or is under common control with an insolvent insurer on December thirty-first of the year immediately preceding the date the insurer becomes an insolvent insurer;

(4) "Association", the Missouri property and casualty insurance guaranty association;

(5) "Claimant", any insured making a first-party claim or any person instituting a liability claim, provided that no person who is an affiliate of the insolvent insurer may be a claimant;

(6) "Control", the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with the corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds the power to vote, or holds proxies representing ten percent or more of the voting securities of any other person. Such presumption may be rebutted by a showing that control does not exist in fact;

(7) "Covered claim", an unpaid claim including those for

unearned premiums, presented by a claimant within the time specified in accordance with subsection 1 and subdivision (2) of subsection 2 of section [375.670, and which arises] 375.775, and is for a loss arising out of and is within the coverage of an insurance policy to which sections 375.771 to 375.779 apply [issued by a member insurer, if such insurer becomes an insolvent insurer after September 28, 1971,] made by a person insured under such policy or by a person suffering injury or for which a person insured under such policy is legally liable, if:

(a) The policy is issued by a member insurer and such member insurer becomes an insolvent insurer after August 28, 2004; and

(b) The claimant or insured is a resident of this state at the time of the insured event[;], or the claim is a first-party claim by an insured for damage to property and the property from which the claim arises is permanently located in this state[.] or in the case of an unearned premium, the policyholder is a resident of this state at the time the policy is issued. The residency of the claimant, insured, or policyholder, other than an individual, is the state in which its principal place of business is located at the time of the insured event;

(c) "Covered claim" shall not include:

a. Any amount awarded as punitive or exemplary damages, or which is a fine or penalty;

b. Any amount sought as a return of premium under any retrospective rating plan[,]; or

c. Any amount due any reinsurer, insurer, insurance pool, or underwriting association, health maintenance organization, hospital plan corporation, health services corporation, or self-insurer as subrogation recoveries, reinsurance recoveries, contribution, indemnity, or otherwise[, and]. To the extent of any amount due any reinsurer, insurer, insurance pool, or underwriting association, health maintenance organization, hospital plan corporation, health services corporation, or self-insurer as subrogation recoveries or otherwise there shall be no right of recovery by any person against a tortfeasor insured of an insolvent insurer, except that such limitation shall not apply with respect to those amounts that exceed the limits of the policy issued such tortfeasor by the insolvent insurer[. "Covered claim" shall not include];

d. A claim by or against an insured of an insolvent insurer, if such insured has a net worth of more than twenty-five million dollars on the [date the insurer became an insolvent insurer] later of the end of the insured's most recent fiscal year or the December thirty-first of the year next preceding the date the insurer becomes an insolvent insurer; provided that an insured's net worth on such date shall be deemed to include the aggregate net worth of the insured and all of its affiliates as

calculated on a consolidated basis;

e. Any first-party claim by an insured which is an affiliate of the insolvent insurer;

f. Supplementary payment obligations incurred prior to the final order of liquidation, including but not limited to adjustment fees and expenses, fees for medical cost containment services, including but not limited to medical case management fees, attorney's fees and expenses, court costs, penalties, and bond premiums;

g. Any claims for interest;

h. Any amount that constitutes a portion of a covered claim that is within an insured's deductible or self-insured retention;

i. Any fee or other amount sought by or on behalf of an attorney or other provider of goods or services retained by an insured or claimant in connection with the assertion or prosecuting of any claim, covered or otherwise, against the association;

j. Any amount that constitutes a claim under a policy issued by an insolvent insurer with a deductible or self-insured retention of three hundred thousand dollars or more. However, such a claim shall be considered a covered claim, if, as of the deadline set forth for the filing of claims against the insolvent insurer or its liquidator, the insured is a debtor under 11 U.S.C. Section 701, et seq.;

k. Any amount to the extent that it is covered by any insurance that is available to the claimant or the insured, whether such other insurance is primary, pro rata, or excess. In all such instances, the association's obligations to the insured or claimant shall not be deemed to be other insurance;

[(3)**]** (8) "Insolvent insurer", an insurer licensed to transact insurance in this state, either at the time the policy was issued or when the insured event occurred, and against whom **[**an**]** a final order of liquidation with a finding of insolvency has been entered by a court of competent jurisdiction in the insurer's state of domicile or of this state under the provisions of sections 375.950 to 375.990 or sections 375.1150 to 375.1246, and which such order of liquidation has not been stayed or been the subject of a writ of supersedeas or other comparable order;

(9) "Insured", any named insured, additional insured, vendor, lessor, or any other party identified as an insured under the policy;

[(4)**]** (10) "Member insurer", any person who writes any kind of insurance to which sections 375.771 to 375.779 apply, including the exchange of reciprocal or interinsurance contracts, and possesses a certificate of authority to transact the business of insurance in this state issued by the director of the department of insurance **[**except an insurer which was insolvent on September 28, 1971**]**. Whether or not approved by the director of

the department of insurance for the placing of lines of insurance by [brokers] producers so authorized under the provisions of chapter 384, RSMo, an insurance company not licensed to do business in this state shall not be a member insurer. Missouri mutual and extended Missouri mutual insurance companies doing business under chapter 380, RSMo, shall be considered member insurers for the purposes of sections 375.771 to 375.779, and a special account shall be established applicable only to such companies;

[(5)] (11) "Net direct written premiums", direct gross premiums written in this state on insurance policies to which sections 375.771 to 375.779 apply, less return premiums thereon and dividends paid or credited to policyholders on such direct business. "Net direct written premiums" does not include premiums on contracts between insurers or reinsurers;

[(6)] (12) "Net worth", the total assets of a person less the total liabilities against those assets. Where the person is one who prepares an annual report to shareholders such report for the fiscal year immediately preceding the date of insolvency of the insurance carrier shall be used to determine net worth. If the person is one who does not prepare such an annual report, but does prepare an annual financial report for management which reflects net worth, then such report for the fiscal year immediately preceding the date of insolvency of the insurance

carrier shall be used to determine net worth;

(13) "Ocean marine insurance", includes marine insurance that insures against maritime perils or risks and other related perils or risks which are usually insured against by traditional marine insurance, such as hull and machinery, marine builders' risks, and marine protection and indemnity. Such perils and risks insured against include, without limitation, loss, damage, or expense or legal liability of the insured arising out of an incident related to ownership, operation, chartering, maintenance, use, repair, or construction of any vessel, craft, or instrumentality in use in ocean or inland waters for commercial purposes, including liability of the insured for personal injury, illness, or death for loss or damage to the property of the insured or another person;

[(7)**]** (14) "Person", any individual, corporation, partnership, association or voluntary organization, municipality, or political subdivision;

(15) "Political subdivision", the same meaning as such term is defined in section 70.210, RSMo;

(16) "Self-insurer", a person that covers its liability through a qualified individual or group self-insurance program or any other formal program created for the specific purpose of covering liabilities typically covered by insurance.

375.773. 1. For purposes of administration and assessment,

the association shall be divided into four separate accounts:

(1) The workers' compensation insurance account;

(2) The automobile insurance account;

(3) The Missouri mutual and extended Missouri mutual insurance company account; and

(4) The account for all other insurance to which sections 375.771 to 375.779 apply.

2. Sections 375.771 to 375.779 shall apply to all kinds of direct insurance**[**, except life, accident and sickness, title, surety, disability, credit, mortgage guaranty, ocean marine insurance, and assessment insurance written under the provisions of chapter 383, RSMo**]**, but shall not be applicable to the following:

(1) Life, annuity, accident, and health or disability insurance;

(2) Mortgage guaranty, financial guaranty, or other forms of insurance offering protection against investment risk;

(3) Fidelity or surety bonds, or any other bonding obligations;

(4) Credit insurance, vendors' single-interest insurance, or collateral protection insurance, or any similar insurance protecting the interest of a creditor arising out of a creditor-debtor transaction;

(5) Insurance of warranties or service contracts, including

insurance that provides for the repair, replacement, or service of goods or property, or indemnification for repair, replacement, or service for the operational or structural failure of the goods or property due to a defect in material, workmanship, or normal wear and tear, or provides reimbursement for the liability incurred by the issuers of agreements or service contracts that provide such benefits;

(6) Title insurance;

(7) Ocean marine insurance;

(8) Any transaction or combination of transactions between a person, including affiliates of such person, and an insurer, including affiliates of such insurer, which involves the transfer of investment or credit risk unaccompanied by the transfer of insurance risk;

(9) That portion of any insurance provided or guaranteed by any government;

(10) Insurance written by a company formed and operating under the provisions of sections 383.010 to 383.040, RSMo.

375.774. 1. The association shall issue to each insurer paying an assessment under sections 375.771 to 375.779 a certificate of contribution, in appropriate form and terms as prescribed by the director, for the amount so paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue.

2. A certificate of contribution [issued before September 1, 1991,] may be shown by the insurer in its financial statements as an admitted asset for such amount and period of time, as follows:

(1) One hundred percent for the calendar year of issuance;

(2) Sixty-six and two-thirds percent for the first calendar year after the year of issuance;

(3) Thirty-three and one-third percent for the second year after the year of issuance which shall be the last year each such certificate shall be carried as an asset[;

(4) An insurer shall not show a certificate of contribution issued on and after September 1, 1991, in its financial statements as an admitted asset].

3. The insurer shall be entitled to a credit against the premium tax liability under sections 148.310 to 148.461, RSMo, for contributions paid to the association. This tax credit shall be taken over a period of the three successive tax years beginning after the year of contribution at the rate of thirty-three and one-third percent, per year, of the contribution paid to the association, and such credit shall not be subject to subsection 1 of section 375.916.

4. Any sums recovered by the association representing sums which have theretofore been written off by contributing insurers and offset against premium taxes as provided in subsection 3 of

this section shall be paid by the association to the director of revenue who shall handle such funds in the same manner as provided in section 148.380, RSMo.

5. The association shall be exempt from payment of all fees and all capitation or poll and excise taxes levied by this state or any of its political subdivisions and the real and personal property of the association is hereby declared to be property actually and regularly used exclusively for purposes purely charitable and not held for private or corporate profit within the meaning of subdivision (5) of section 137.100, RSMo 1986.

375.775. 1. The association shall**[**:

(1)**]** Be obligated to the extent of the covered claims existing prior to the date of a final order of liquidation or a judicial determination by a court of competent jurisdiction in the insurer's domiciliary state that an insolvent insurer exists and arising within thirty days from the date or at the time of the first such order or determination, or before the policy expiration date if less than thirty days after such date, or before or at the time the insured replaces the policy or causes its cancellation, if he does so within thirty days of such date**[**, but obligation shall include only that amount of each covered claim which is in excess of one hundred dollars and is less than three hundred thousand dollars, except that the association shall pay the full amount of any covered claim arising out of a

workers' compensation policy**]**. Such obligation shall be satisfied by paying to the claimant an amount as follows:

(1) The full amount of a covered claim for benefits under workers' compensation insurance coverage;

(2) An amount not exceeding twenty-five thousand dollars per policy for a covered claim for the return of unearned premium;

(3) An amount not exceeding three hundred thousand dollars per claim for all other covered claims.

2. In no event shall the association be obligated to an insured or claimant in an amount in excess of the face amount or the limits of the policy from which a claim arises or be obligated for the payment of unearned premium in excess of the amount of **[**ten**]** twenty-five thousand dollars, or to an insured or claimant on any covered claim until it receives confirmation from the receiver or liquidator of an insolvent insurer that the claim is within the coverage of an applicable policy of the insolvent insurer, except that within the sole discretion of the association, if the association deems it has sufficient evidence from other sources, including any claim forms which may be propounded by the association, that the claim is within the coverage of an applicable policy of the insolvent insurer, it shall proceed to process the claim, pursuant to its statutory obligations, without such confirmation by the receiver or

liquidator:

[(a)**]** (1) All covered claims shall be filed with the association on the claim information form required by this paragraph no later than the final date first set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer, except that if the time first set by the court for filing claims is one year or less from the date of insolvency, and an extension of the time to file claims is granted by the court, claims may be filed with the association no later than the new date set by the court or within one year of the date of insolvency, whichever first occurs. In no event shall the association be obligated on a claim filed after such date or on one not filed on the required form. A claim information form shall consist of a statement verified under oath by the claimant which includes all of the following:

[a.**]** (a) The particulars of the claim;

[b.**]** (b) A statement that the sum claimed is justly owing and that there is no setoff, counterclaim, or defense to said claim;

[c.**]** (c) The name and address of the claimant and the attorney who represents the claimant, if any; and

[d.**]** (d) If the claimant is an insured, that the insured's net worth did not exceed twenty-five million dollars on the date the insurer became an insolvent insurer.

The association may require that a prescribed form be used and may require that other information and documents be included. A covered claim shall not include any claim not described in a timely filed claim information form even though the existence of the claim was not known to the claimant at the time a claim information form was filed;

[(b)**]** (2) In the case of claims arising from a member insurer subject to a final order of liquidation issued on or after September 1, 2000, the provisions of **[**paragraph (a) of subdivision (1) of subsection 1**]** subdivision (1) of subsection 2 of this section shall not apply and in lieu thereof, such claims shall be governed by this **[**paragraph**]** subdivision. All covered claims shall be filed with the association, liquidator or receiver **[**no later than the final date first set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer, except that if the time first set by the court for filing claims is one year or less from the date of the insolvency, and an extension of the time to file claims is granted by the court, claims may be filed no later than the new date set by the court or within one year of the date of insolvency, whichever first occurs**]**. Notwithstanding any other provisions of sections 375.771 to 375.779, a covered claim shall not include a claim filed after the earlier of eighteen months after the date of the order of liquidation, or the final date set

by the court for the filing of claims against the liquidator or receiver of an insolvent insurer. The association may require [that the prescribed forms be used and may require] that other information and documents be included in confirming the existence of a covered claim or in determining eligibility of any claimant. Such information may include, but is not limited to:

[a.] (a) The particulars of the claim;

[b.] (b) A statement that the sum claimed is justly owing and that there is [not] no setoff, counterclaim, or defense to said claim;

[c.] (c) The name and address of the claimant and the attorney who represents the claimant, if any; and

[d.] (d) A verification under oath of such requested information.

In no event shall the association be obligated on a claim filed with the association, liquidator or receiver for protection afforded under the insured's policy for incurred but not reported losses. A covered claim shall not include any claim that is not filed prior to the final date for filing claims, even though the existence of the claims was not known to the claimant prior to such final date;

[(c)] 3. In the case of claims arising from bodily injury, sickness or disease, the amount of any such award shall not

exceed the claimant's reasonable expenses incurred for necessary medical, surgical, X-ray, dental services and comparable services for individuals who, in the exercise of their constitutional rights, rely on spiritual means alone for healing in accordance with the tenets and practices of a recognized church or religious denomination by a duly accredited practitioner thereof, including prosthetic devices and necessary ambulance, hospital, professional nursing, and any amounts lost or to be lost by reason of claimant's inability to work and earn wages or salary or their equivalent, except that the association shall pay the full amount of any covered claim arising out of a workers' compensation policy. Such award may also include payments in fact made to others, not members of claimant's household, which were reasonably incurred to obtain from such other persons ordinary and necessary services for the production of income in lieu of those services the claimant would have performed for himself had he not been injured. Verdicts as respect only those civil actions as may be brought to recover damages as provided in this section shall specifically set out the sums applicable to each item in this section for which an award may be made**[;]**.

4. In the case of claims arising from a member insurer subject to a final order of liquidation dated on or after August 28, 2004, the provisions of subsection 3 of this section shall not apply.

5. Notwithstanding any other provision of sections 375.771 to 375.779, except in the case of a claim for benefits under workers' compensation coverage, any obligation of the association to or on behalf of the insured and its affiliates on covered claims shall cease when ten million dollars has been paid in the aggregate by the association and any one or more associations similar to the association in any other state or states to or on behalf of such insured, its affiliates, and additional insureds on covered claims or allowed claims arising under the policy or policies of any one insolvent insurer.

6. If the association determines that there may be more than one claimant having a covered claim or allowed claim against the association, or any associations similar to the association in other states, under the policy or policies of any one solvent insurer, the association may establish a plan to allocate amounts payable by the association in such manner as the association in its discretion deems equitable.

[(2)**]** 7. The association shall be deemed the insurer only to the extent of its obligations on the covered claims and to such extent, subject to the limitations provided in sections 375.771 to 375.779, shall have all rights, duties, and obligations of the insolvent insurer as if the insurer had not become insolvent**[**;**]**, including but not limited to the right to pursue and retain salvage and subrogation recoverable on paid

covered claim obligations. The association shall not be deemed the insolvent insurer for any purpose relating to the issue of whether the association is amenable to the personal jurisdiction of the courts of any states. However, any obligation to defend an insured shall cease upon:

(1) The association's payment by settlement releasing the insured or on a judgment of an amount equal to the lesser of the association's covered claim obligation limit or the applicable policy limit; or

(2) The association's tender of such amount.

[(3)**]** 8. The association shall allocate claims paid and expenses incurred among the four accounts separately, and assess member insurers separately for each account amounts necessary to pay the obligations of the association under **[**subdivision (1) of this**]** subsection 1 of this section to an insolvency, the expenses of handling covered claims subsequent to an insolvency, the cost of examinations under subdivision **[**(6) of this subsection**]** (3) of subsection 9 of this section, and other expenses authorized by sections 375.771 to 375.779. The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the preceding calendar year on the kinds of insurance in the account bears to the net direct written premiums of all member insurers for the preceding calendar year of the kinds of insurance in the account. Each

member insurer's assessment may be rounded to the nearest ten dollars. Each member insurer shall be notified of the assessment not later than thirty days before it is due. No member insurer may be assessed in any year on any account an amount greater than [one] two percent of that member insurer's net direct written premiums for the preceding calendar year on the kinds of insurance in the account. If the maximum assessment, together with the other assets of the association in any account, does not provide in any one year in any account an amount sufficient to make all necessary payments from that account, the funds available shall be prorated and the unpaid portion shall be paid as soon thereafter as funds become available. The association may defer, in whole or in part, the assessment of any member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance. Deferred assessments shall be paid when such payment will not reduce capital or surplus below required minimums. Such payments shall be refunded to those companies receiving larger assessments by virtue of such deferment, or, in the discretion of any such company, credited against future assessments. No dividends shall be paid stockholders or policyholders of a member insurer so long as all or part of any

assessment against such insurer remains deferred. Each member insurer may set off against any assessment, authorized payments made on covered claims and expenses incurred in the payment of such claims by the member insurer if they are chargeable to the account for which the assessment is made. Assessments made under sections 375.771 to 375.779 and section 375.916 shall not be subject to subsection 1 of section 375.916;

[(4)**]** 9. The association shall:

(1) Handle claims through its employees or through one or more insurers or other persons designated as servicing facilities. Designation of a servicing facility is subject to the approval of the director, but such designation may be declined by a member insurer;

[(5)**]** (2) Reimburse each servicing facility for obligations of the association paid by the facility and for actual expenses incurred by the facility while handling claims on behalf of the association and shall pay the other expenses of the association authorized by this section;

[(6)**]** (3) Be subject to examination and regulation by the director. The board of directors shall submit, not later than March thirtieth of each year, a financial report for the preceding calendar year in a form approved by the director; and

[(7) Be considered to have been designated commissioner pursuant to subsection 2 of section 375.670, and it shall proceed

to investigate, hear, settle, and determine covered claims unless the claimant shall, within thirty days from the date the claim is presented, present a written demand that such claim be processed in the liquidation proceedings as a claim not covered by sections 375.771 to 375.779**]** (4) Proceed to investigate, settle, and determine covered claims.

[2.**]** 10. The association may:

(1) Appear in, defend and appeal any action on a claim brought against the association;

(2) Employ or retain such persons as are necessary to handle claims and perform other duties of the association;

(3) Act as a servicing facility for other similar entities created by similar laws in this state or other states;

(4) Borrow funds necessary to effect the purposes of sections 375.771 to 375.779 in accord with the plan of operation;

[(4)**]** (5) Sue or be sued. Such power to sue includes the power and right to intervene as a party before any court that has jurisdiction over an insolvent insurer as defined in section 375.772;

[(5)**]** (6) Negotiate and become a party to such contracts as are necessary to carry out the purpose of sections 375.771 to 375.779;

[(6)**]** (7) Perform such other acts as are necessary or proper to effectuate the purpose of sections 375.771 to 375.779;

[(7)**]** (8) Refund to the member insurers in proportion to the contribution of each member insurer to that account that amount by which the assets of the account exceed the liabilities, if, at the end of any calendar year, the board of directors finds that the assets of the association in any account exceed the liabilities of that account as estimated by the board of directors for the coming year; and

[(8)**]** (9) Become a member of the National **[**Committee**]** Conference on Insurance Guaranty Funds.

375.776. 1. The board of directors, subject to the supervision of the director, shall:

(1) Establish a plan of operation whereby the duties of the association under section 375.775 will be performed;

(2) Establish procedures for handling assets of the association;

(3) Establish regular places and times for meetings of the board of directors;

(4) Establish procedures for records to be kept of all financial transactions of the association, its agents, and the board of directors;

(5) Provide that any member insurer aggrieved by any final action or decision of the association may appeal to the director within thirty days after the action or decision;

(6) Establish the procedures whereby selections for the

board of directors will be submitted to the director; and

(7) Have and exercise such additional powers necessary or proper for the execution of the powers and duties of the association.

2. The plan of operation may provide that any or all powers and duties of the association, except those under **[**subdivision (3) of subsection 1 and subdivision (3) of subsection 2**]** subsection 8 and subdivision (4) of subsection 10 of section 375.775, are delegated to a corporation, association, or organization which performs or will perform functions similar to those of this association, or its equivalent, in two or more states. Such a corporation, association or organization shall be reimbursed as a servicing facility would be reimbursed and shall be paid for its performance of any other functions of the association. A delegation under this section shall take effect only with the approval of both the board of directors and the director, and may be made only to a corporation, association, or organization which extends protection not substantially less favorable and effective than that provided by sections 375.771 to 375.779.

3. The board of directors of the association shall consist of seven persons serving terms as established in the plan of operation. The members of the board shall be selected by member insurers subject to the approval of the director. Not less than

four of the members shall represent domestic insurers. Vacancies on the board shall be filled for the remaining period of the term by appointment of the director. If no members are selected within sixty days, the director shall appoint the initial members of the board of directors.

4. Members of the board shall receive no remuneration.

5. To aid in the detection and prevention of insurer insolvencies:

(1) It shall be the duty of the board of directors, upon majority vote, to notify the director of any information indicating any member insurer may be insolvent or in a financial condition hazardous to the policyholders or the public;

(2) The board of directors may, upon majority vote, make reports and recommendations to the director upon any matter germane to the solvency, liquidation, rehabilitation or conservation of any member insurer. Such reports and recommendations shall not be considered public documents; and

(3) The board of directors shall, at the conclusion of any insurer insolvency in which the association was obligated to pay covered claims, prepare a report on the history and causes of such insolvency, based on the information available to the association, and submit such report to the director.

375.778. 1. Any person having a claim against **[**his**]** an insurer, regardless of whether such insurer is a member insurer,

under any provision in [his] an insurance policy, other than the policy of the insolvent insurer, which arises out of the same facts, injury, or loss that gave rise to the covered claim against the association and which is also a covered claim shall [first] be required to first exhaust his or her right under such policy[. Any amount payable on a covered claim under sections 375.771 to 375.779 shall be reduced by the amount of such recovery under the claimant's insurance policy] or policies of insurance. Such other policies of insurance shall include, but not be limited to, liability coverage, health and accident insurance, hospitalization and other medical expense coverage, health care coverage by a health maintenance organization or health services corporation, or any amount payable by or on behalf of a self-insured plan, workers' compensation benefits, disability insurance, uninsured motorist coverage, and underinsured motorist coverage. The association's obligation pursuant to subsection 1 of section 375.775 shall be reduced by the amount recovered or recoverable, whichever is greater under any such other insurance policy or policies. To the extent the association's obligation pursuant to subsection 1 of section 375.775 is reduced by the application of the section, the liability of the person insured by the insolvent insurer's policy for the claim shall be reduced in the same amount.

2. Any person having a claim which may be recovered under

more than one insurance guaranty association or its equivalent shall first seek recovery from the association of the place of residence of the insured except that if it is a first party claim for damage to property with a permanent location, from the association of the location of the property, and if it is a workers' compensation claim, from the association of the residence of the claimant. Any recovery under sections 375.771 to 375.779 shall be reduced by the amount of the recovery from any other insurance guaranty association or its equivalent.

3. Any person having a claim or legal right of recovery against any governmental insurance or guaranty program that is also a covered claim shall be required to exhaust first such rights under that program. Any amount payable on a covered claim by the association shall be reduced by the amount of recovery under the program.

4. The association shall have no duty to provide a separate defense at its cost to an insured of an insolvent insurer as to any issue arising out of the coverage of this section.

5. (1) Any person recovering under sections 375.771 to 375.779 shall be deemed to have assigned his or her rights under the policy to the association to the extent of his or her recovery from the association. Every insured or claimant seeking the protection of sections 375.771 to 375.779 shall cooperate with the association to the same extent as such person

would have been required to cooperate with the insolvent insurer.

(2) [Any person eligible to recover a covered claim under sections 375.771 to 375.779 shall have the right to assign such rights of recovery to the agent of the insolvent member insurer.

(3)] The association shall periodically file with the receiver or liquidator of the insolvent insurer statements of the covered claims paid by the association and estimates of anticipated claims on the association which shall preserve the rights of the association against the assets of the insolvent insurer.

[4. All proceedings in which the insolvent insurer is a party or is obligated to defend a party in any court in this state shall be stayed for sixty days from the date the insolvency is determined. In addition, the association, upon application to any court in which the insolvent insurer is a party or is obligated to defend a party and upon showing that the association first received notice from the insured or claimant of such claim or lawsuit not more than twenty days prior to making the application, shall be granted a continuance of not less than sixty days from any trial setting.]

6. All proceedings in which the insolvent insurer is a party or is obligated to defend a party in any court of this state shall, subject to waiver by the association in specific cases involving covered claims, be stayed until the last day

fixed by the court for the filing of claims and such additional time thereafter as may be determined by the court from the date the insolvency is determined or an ancillary proceeding is instituted in the state, whichever is later, to permit proper defense by the association of all pending causes of action.

7. As to any covered claims arising from a judgment under any decision, verdict or finding based on the default of the insolvent insurer or its failure to defend an insured, the association, either on its own behalf or on behalf of such insured, may apply to have such judgment, order, decision, verdict or finding set aside by the same court or administrator that made such judgment, order, decision, verdict or finding and shall be permitted to defend against such claim on the merits, even if the time otherwise provided by law for setting aside a default judgment has expired.

[5.**]** 8. With respect to a subrogation claim arising out of payment for property damage caused by a tortfeasor insured by an insolvent insurer, the insurer making such payment shall not be entitled to any right of recovery against such tortfeasor in excess of the proceeds recovered from the assets of the insolvent insurer of such tortfeasor; provided that, such limitation shall not apply with respect to property damage in excess of the limits of liability of the policy issued such tortfeasor by the insolvent insurer.

[6.**]** 9. The liquidator, receiver, or statutory receiver of an insolvent member insurer covered by sections 375.771 to 375.779 shall permit access by the board of directors of the association or its authorized representative to such of the insolvent insurer's records which are necessary for the board in carrying out its functions under sections 375.771 to 375.779 with regard to covered claims. In addition, the liquidator, receiver, or statutory receiver shall provide the board or its representatives with copies of such records upon the request by the board and at the expense of the board.

375.779. 1. There shall be no liability on the part of and no cause of action of any nature shall arise against any member insurer, the association or its agents **[**or**]**, employees, or any servicing agent acting at the direction of the association, the board of directors or any person serving as a representative of any director, or the director of the department of insurance or **[**his**]** the director's representatives for any action taken by them in the performance of their powers and duties under sections 375.771 to 375.779.

2. It is an unfair trade practice for any insurer or **[**agent**]** producer to make use in any manner of the protection given policyholders by sections 375.771 to 375.779 as a reason for buying insurance from **[**him**]** such insurer or producer. If a policy exceeds the limitations of coverage under sections 375.771

to 375.779, the insurer shall prominently inscribe on an endorsement to the insurance contract the limitations of coverage provided by the guaranty association.

375.1220. 1. The liquidator shall review all claims duly filed in the liquidation and shall make such further investigation as the liquidator shall deem necessary. The liquidator may compound, compromise or in any other manner negotiate the amount for which claims will be allowed, under the supervision of the court, except where the liquidator is required by law to accept claims as settled by any person or organization. Unresolved disputes shall be determined pursuant to section 375.1214. No claim under a policy of insurance shall be allowed for any amount in excess of the applicable policy limits or without regard to policy deductibles.

2. If the fixing or liquidation of any claim or claims would unduly delay the administration of the liquidation or if the administrative expense of processing and adjudication of a claim or group of claims of a similar type would be unduly excessive when compared with the moneys which are estimated to be available for distribution with respect to such claim or group of claims, the determination and allowance of such claim or claims may be made by an estimate. Any such estimate shall be based upon an actuarial evaluation made with reasonable actuarial certainty or upon another accepted method of valuing claims with

reasonable certainty.

3. The estimation of contingent liabilities permitted by subsection 2 of this section or any other section of this chapter may be used for the purpose of fixing a creditor's claim in the estate, and for determining the percentage of partial or final dividend payments to be paid to creditors with reported allowed claims. However, nothing in subsection 2 of this section or any other section in this chapter shall be construed as authorizing the receiver, or any other entity, to compel payment from a reinsurer on the basis of estimated incurred but not reported losses and, except with respect to claims made pursuant to section 375.1212, outstanding reserves. Nothing in this subsection shall be construed to impair any obligation arising pursuant to any insurance agreement.

4. Notwithstanding the provisions of this section or any other section of this chapter to the contrary, the liquidator may negotiate a voluntary commutation and release of all obligations arising from reinsurance contracts or other agreements.

5. The provisions of subsection 3 of this section shall not apply to and have no force and effect regarding any formal delinquency proceeding in which, prior to August 28, 1999, the court in which such proceeding was or is pending issued any order or decree construing or applying the provisions of this section.

[6. Subsections 3 and 5 of this section shall terminate on

December 31, 2005.**]**

376.421. 1. Except as provided in subsection 2 of this section, no policy of group health insurance shall be delivered in this state unless it conforms to one of the following descriptions:

(1) A policy issued to an employer, or to the trustees of a fund established by an employer, which employer or trustees shall be deemed the policyholder, to insure employees of the employer for the benefit of persons other than the employer, subject to the following requirements:

(a) The employees eligible for insurance under the policy shall be all of the employees of the employer, or all of any class or classes thereof. The policy may provide that the term "employees" shall include the employees of one or more subsidiary corporations, and the employees, individual proprietors, and partners of one or more affiliated corporations, proprietorships or partnerships, if the business of the employer and of such affiliated corporations, proprietorships or partnerships is under common control. The policy may provide that the term "employees" shall include the individual proprietor or partners if the employer is an individual proprietorship or partnership. The policy may provide that the term "employees" shall include retired employees, former employees and directors of a corporate employer. A policy issued to insure the employees of a public

body may provide that the term "employees" shall include elected or appointed officials;

(b) The premium for the policy shall be paid either from the employer's funds or from funds contributed by the insured employees, or from both. Except as provided in paragraph (c) of this subdivision, a policy on which no part of the premium is to be derived from funds contributed by the insured employees must insure all eligible employees, except those who reject such coverage in writing; and

(c) An insurer may exclude or limit the coverage on any person **[**as to whom evidence of individual insurability is not satisfactory to the insurer in a policy insuring fewer than ten employees and in a policy insuring ten or more employees if:

a. Application is not made within thirty-one days after the date of eligibility for insurance; or

b. The person voluntarily terminated the insurance while continuing to be eligible for insurance under the policy; or

c. After the expiration of an open enrollment period during which the person could have enrolled for the insurance or could have elected another level of benefits under the policy**]** only to the extent authorized by sections 376.450 to 376.452;

(2) A policy issued to a creditor or its parent holding company or to a trustee or trustees or agent designated by two or more creditors, which creditor, holding company, affiliate,

trustee, trustees or agent shall be deemed the policyholder, to insure debtors of the creditor or creditors with respect to their indebtedness subject to the following requirements:

(a) The debtors eligible for insurance under the policy shall be all of the debtors of the creditor or creditors, or all of any class or classes thereof. The policy may provide that the term "debtors" shall include:

a. Borrowers of money or purchasers or lessees of goods, services, or property for which payment is arranged through a credit transaction;

b. The debtors of one or more subsidiary corporations; and

c. The debtors of one or more affiliated corporations, proprietorships or partnerships if the business of the policyholder and of such affiliated corporations, proprietorships or partnerships is under common control;

(b) The premium for the policy shall be paid either from the creditor's funds or from charges collected from the insured debtors, or from both. Except as provided in paragraph (c) of this subdivision, a policy on which no part of the premium is to be derived from funds contributed by insured debtors specifically for their insurance must insure all eligible debtors;

(c) An insurer may exclude any debtors as to whom evidence of individual insurability is not satisfactory to the insurer in a policy insuring fewer than ten debtors and in a policy insuring

ten or more debtors if:

a. Application is not made within thirty-one days after the date of eligibility for insurance; or

b. The person voluntarily terminated the insurance while continuing to be eligible for insurance under the policy; or

c. After the expiration of an open enrollment period during which the person could have enrolled for the insurance or could have elected another level of benefits under the policy;

(d) The total amount of insurance payable with respect to an indebtedness shall not exceed the greater of the scheduled or actual amount of unpaid indebtedness to the creditor. The insurer may exclude any payments which are delinquent on the date the debtor becomes disabled as defined in the policy;

(e) The insurance may be payable to the creditor or to any successor to the right, title, and interest of the creditor. Such payment or payments shall reduce or extinguish the unpaid indebtedness of the debtor to the extent of each such payment and any excess of insurance shall be payable to the insured or the estate of the insured;

(f) Notwithstanding the preceding provisions of this subdivision, insurance on agricultural credit transaction commitments may be written up to the amount of the loan commitment, and insurance on educational credit transaction commitments may be written up to the amount of the loan

commitment less the amount of any repayments made on the loan;

(3) A policy issued to a labor union or similar employee organization, which shall be deemed to be the policyholder, to insure members of such union or organization for the benefit of persons other than the union or organization or any of its officials, representatives, or agents, subject to the following requirements:

(a) The members eligible for insurance under the policy shall be all of the members of the union or organization, or all of any class or classes thereof;

(b) The premium for the policy shall be paid either from funds of the union or organization or from funds contributed by the insured members specifically for their insurance, or from both. Except as provided in paragraph (c) of this subdivision, a policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance must insure all eligible members, except those who reject such coverage in writing;

(c) An insurer may exclude or limit the coverage on any person **[**as to whom evidence of individual insurability is not satisfactory to the insurer in a policy insuring fewer than ten members and in a policy insuring ten or more members if:

a. Application is not made within thirty-one days after the date of eligibility for insurance; or

b. The person voluntarily terminated the insurance while continuing to be eligible for insurance under the policy; or

c. After the expiration of an open enrollment period during which the person could have enrolled for the insurance or could have elected another level of benefits under the policy**]** only to the extent authorized by sections 376.450 to 376.452;

(4) A policy issued to a trust, or to the trustee of a fund, established or adopted by two or more employers, or by one or more labor unions or similar employee organizations, or by one or more employers and one or more labor unions or similar employee organizations, which trust or trustee shall be deemed the policyholder, to insure employees of the employers or members of the unions or organizations for the benefit of persons other than the employers or the unions or organizations, subject to the following requirements:

(a) The persons eligible for insurance shall be all of the employees of the employers or all of the members of the unions or organizations, or all of any class or classes thereof. The policy may provide that the term "employees" shall include the employees of one or more subsidiary corporations, and the employees, individual proprietors, and partners of one or more affiliated corporations, proprietorships or partnerships if the business of the employer and of such affiliated corporations, proprietorships or partnerships is under common control. The

policy may provide that the term "employees" shall include the individual proprietor or partners if the employer is an individual proprietorship or partnership. The policy may provide that the term "employees" shall include retired employees, former employees and directors of a corporate employer. The policy may provide that the term "employees" shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship;

(b) The premium for the policy shall be paid from funds contributed by the employer or employers of the insured persons or by the union or unions or similar employee organizations, or by both, or from funds contributed by the insured persons or from both the insured persons and the employer or union or similar employee organization. Except as provided in paragraph (c) of this subdivision, a policy on which no part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance, must insure all eligible persons except those who reject such coverage in writing;

(c) An insurer may exclude or limit the coverage on any person **[**as to whom evidence of individual insurability is not satisfactory to the insurer**]** only to the extent authorized by sections 376.450 to 376.452;

(5) A policy issued to an association or to a trust or to the trustees of a fund established, created and maintained for

the benefit of members of one or more associations. The association or associations shall have at the outset a minimum of one hundred persons; shall have been organized and maintained in good faith for purposes other than that of obtaining insurance; shall have been in active existence for at least two years; shall have a constitution and bylaws which provide that the association or associations shall hold regular meetings not less than annually to further the purposes of the members; shall, except for credit unions, collect dues or solicit contributions from members; and shall provide the members with voting privileges and representation on the governing board and committees. The policy shall be subject to the following requirements:

(a) The policy may insure members of such association or associations, employees thereof, or employees of members, or one or more of the preceding, or all of any class or classes thereof for the benefit of persons other than the employee's employer;

(b) The premium for the policy shall be paid from funds contributed by the association or associations or by employer members, or by both, or from funds contributed by the covered persons or from both the covered persons and the association, associations, or employer members;

(c) Except as provided in paragraph (d) of this subdivision, a policy on which no part of the premium is to be derived from funds contributed by the covered persons

specifically for their insurance must insure all eligible persons, except those who reject such coverage in writing;

(d) An insurer may exclude or limit the coverage on any person [as to whom evidence of individual insurability is not satisfactory to the insurer] only to the extent authorized by sections 376.450 to 376.452;

(6) A policy issued to a credit union or to a trustee or trustees or agent designated by two or more credit unions, which credit union, trustee, trustees or agent shall be deemed the policyholder, to insure members of such credit union or credit unions for the benefit of persons other than the credit union or credit unions, trustee or trustees, or agent or any of their officials, subject to the following requirements:

(a) The members eligible for insurance shall be all of the members of the credit union or credit unions, or all of any class or classes thereof;

(b) The premium for the policy shall be paid by the policyholder from the credit union's funds and, except as provided in paragraph (c) of this subdivision, must insure all eligible members;

(c) An insurer may exclude or limit the coverage on any member [as to whom evidence of individual insurability is not satisfactory to the insurer] only to the extent authorized by sections 376.450 to 376.452;

(7) A policy issued to cover persons in a group where that group is specifically described by a law of this state as one which may be covered for group life insurance. The provisions of such law relating to eligibility and evidence of insurability shall apply.

2. Group health insurance offered to a resident of this state under a group health insurance policy issued to a group other than one described in subsection 1 of this section shall be subject to the following requirements:

(1) No such group health insurance policy shall be delivered in this state unless the director finds that:

(a) The issuance of such group policy is not contrary to the best interest of the public;

(b) The issuance of the group policy would result in economies of acquisition or administration; and

(c) The benefits are reasonable in relation to the premiums charged;

(2) No such group health insurance coverage may be offered in this state by an insurer under a policy issued in another state unless this state or another state having requirements substantially similar to those contained in subdivision (1) of this subsection has made a determination that such requirements have been met;

(3) The premium for the policy shall be paid either from

the policyholder's funds, or from funds contributed by the covered persons, or from both;

(4) An insurer may exclude or limit the coverage on any person **[**as to whom evidence of individual insurability is not satisfactory to the insurer**]** only to the extent authorized by sections 376.450 to 376.452.

376.424. Except for a policy issued under subdivision (2) of subsection 1 of section 376.421, a group health insurance policy may be extended to insure the employees and members with respect to their family members or dependents, or any class or classes thereof, subject to the following:

(1) The premium for the insurance shall be paid either from funds contributed by the employer, union, association or other person to whom the policy has been issued or from funds contributed by the covered persons, or from both. Except as provided in subdivision (2) of this section, a policy on which no part of the premium for the family members' or dependents' coverage is to be derived from funds contributed by the covered persons must insure all eligible employees or members with respect to their family members or dependents, or any class or classes thereof;

(2) An insurer may exclude or limit the coverage on any family member or dependent **[**as to whom evidence of individual insurability is not satisfactory to the insurer**]**, subject to

sections 376.406 and 376.776 [in a policy insuring fewer than ten employees or members and in a policy insuring ten or more employees or members if:

a. Application is not made within thirty-one days after the date of eligibility for insurance; or

b. The employee or member voluntarily terminated the insurance of the family member or dependent while such family member or dependent continues to be eligible for insurance under the policy; or

c. After the expiration of an open enrollment period during which the family member or dependent could have been enrolled for the insurance or could have been enrolled for another level of benefits under the policy], only to the extent authorized by sections 376.450 to 376.452.

376.426. No policy of group health insurance shall be delivered in this state unless it contains in substance the following provisions, or provisions which in the opinion of the director of insurance are more favorable to the persons insured or at least as favorable to the persons insured and more favorable to the policyholder; except that: Provisions in subdivisions (5), (7), (12), (15), and (16) of this section shall not apply to policies insuring debtors; standard provisions required for individual health insurance policies shall not apply to group health insurance policies; and if any provision of this

section is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the approval of the director, shall omit from such policy any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of the provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy:

(1) A provision that the policyholder is entitled to a grace period of thirty-one days for the payment of any premium due except the first, during which grace period the policy shall continue in force, unless the policyholder shall have given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder shall be liable to the insurer for the payment of a pro rata premium for the time the policy was in force during such grace period;

(2) A provision that the validity of the policy shall not be contested, except for nonpayment of premiums, after it has been in force for two years from its date of issue, and that no statement made by any person covered under the policy relating to insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of two years during such person's lifetime nor unless it

is contained in a written instrument signed by the person making such statement; except that, no such provision shall preclude the assertion at any time of defenses based upon the person's ineligibility for coverage under the policy or upon other provisions in the policy;

(3) A provision that a copy of the application, if any, of the policyholder shall be attached to the policy when issued, that all statements made by the policyholder or by the persons insured shall be deemed representations and not warranties and that no statement made by any person insured shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to such person or, in the event of the death or incapacity of the insured person, to the individual's beneficiary or personal representative;

(4) A provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of the individual's coverage;

(5) A provision specifying the additional exclusions or limitations, if any, applicable under the policy with respect to a disease or physical condition of a person, not otherwise excluded from the person's coverage by name or specific description effective on the date of the person's loss, which

existed prior to the effective date of the person's coverage under the policy. Any such exclusion or limitation [may only apply to a disease or physical condition for which medical advice or treatment was received by the person during the twelve months prior to the effective date of the person's coverage. In no event shall such exclusion or limitation apply to loss incurred or disability commencing after the earlier of:

(a) The end of a continuous period of twelve months commencing on or after the effective date of the person's coverage during all of which the person has received no medical advice or treatment in connection with such disease or physical condition; or

(b) The end of the two-year period commencing on the effective date of the person's coverage] shall comply with the requirements of subsection 5 of section 376.450;

(6) If the premiums or benefits vary by age, there shall be a provision specifying an equitable adjustment of premiums or of benefits, or both, to be made in the event the age of the covered person has been misstated, such provision to contain a clear statement of the method of adjustment to be used;

(7) A provision that the insurer shall issue to the policyholder, for delivery to each person insured, a certificate setting forth a statement as to the insurance protection to which that person is entitled, to whom the insurance benefits are

payable, and a statement as to any family member's or dependent's coverage;

(8) A provision that written notice of claim must be given to the insurer within twenty days after the occurrence or commencement of any loss covered by the policy. Failure to give notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible;

(9) A provision that the insurer shall furnish to the person making claim, or to the policyholder for delivery to such person, such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished before the expiration of fifteen days after the insurer receives notice of any claim under the policy, the person making such claim shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claim is made;

(10) A provision that in the case of claim for loss of time for disability, written proof of such loss must be furnished to the insurer within ninety days after the commencement of the period for which the insurer is liable, and that subsequent

written proofs of the continuance of such disability must be furnished to the insurer at such intervals as the insurer may reasonably require, and that in the case of claim for any other loss, written proof of such loss must be furnished to the insurer within ninety days after the date of such loss. Failure to furnish such proof within such time shall not invalidate nor reduce any claim if it was not reasonably possible to furnish such proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required;

(11) A provision that all benefits payable under the policy other than benefits for loss of time shall be payable not more than thirty days after receipt of proof and that, subject to due proof of loss, all accrued benefits payable under the policy for loss of time shall be paid not less frequently than monthly during the continuance of the period for which the insurer is liable, and that any balance remaining unpaid at the termination of such period shall be paid as soon as possible after receipt of such proof;

(12) A provision that benefits for accidental loss of life of a person insured shall be payable to the beneficiary designated by the person insured or, if the policy contains conditions pertaining to family status, the beneficiary may be

the family member specified by the policy terms. In either case, payment of these benefits is subject to the provisions of the policy in the event no such designated or specified beneficiary is living at the death of the person insured. All other benefits of the policy shall be payable to the person insured. The policy may also provide that if any benefit is payable to the estate of a person, or to a person who is a minor or otherwise not competent to give a valid release, the insurer may pay such benefit, up to an amount not exceeding two thousand dollars, to any relative by blood or connection by marriage of such person who is deemed by the insurer to be equitably entitled thereto;

(13) A provision that the insurer shall have the right and opportunity, at the insurer's own expense, to examine the person of the individual for whom claim is made when and so often as it may reasonably require during the pendency of the claim under the policy and also the right and opportunity, at the insurer's own expense, to make an autopsy in case of death where it is not prohibited by law;

(14) A provision that no action at law or in equity shall be brought to recover on the policy prior to the expiration of sixty days after proof of loss has been filed in accordance with the requirements of the policy and that no such action shall be brought at all unless brought within three years from the expiration of the time within which proof of loss is required by

the policy;

(15) A provision specifying the conditions under which the policy may be terminated. Such provision shall state that except for nonpayment of the required premium or the failure to meet continued underwriting standards, the insurer may not terminate the policy prior to the first anniversary date of the effective date of the policy as specified therein, and a notice of any intention to terminate the policy by the insurer must be given to the policyholder at least thirty-one days prior to the effective date of the termination. Any termination by the insurer shall be without prejudice to any expenses originating prior to the effective date of termination. An expense will be considered incurred on the date the medical care or supply is received;

(16) A provision stating that if a policy provides that coverage of a dependent child terminates upon attainment of the limiting age for dependent children specified in the policy, such policy, so long as it remains in force, shall be deemed to provide that attainment of such limiting age does not operate to terminate the hospital and medical coverage of such child while the child is and continues to be both incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the policyholder for support and maintenance. Proof of such incapacity and dependency must be furnished to the insurer by the policyholder at least thirty-one

days before the child's attainment of the limiting age. The insurer may require at reasonable intervals during the two years following the child's attainment of the limiting age subsequent proof of the child's incapacity and dependency. After such two-year period, the insurer may require subsequent proof not more than once each year. This subdivision shall apply only to policies delivered or issued for delivery in this state on or after one hundred twenty days after September 28, 1985;

(17) In the case of a policy insuring debtors, a provision that the insurer shall furnish to the policyholder for delivery to each debtor insured under the policy a certificate of insurance describing the coverage and specifying that the benefits payable shall first be applied to reduce or extinguish the indebtedness.

376.450. 1. As used in sections 376.450 to 376.452, the following terms mean:

(1) "Affiliation period", a period which, under the terms of the coverage offered by a health maintenance organization, must expire before the coverage becomes effective. The organization is not required to provide health care services or benefits during such period and no premium shall be charged to the participant or beneficiary for any coverage during the period;

(2) "Bona fide association", an association which:

(a) Has been actively in existence for at least five years;

(b) Has been formed and maintained in good faith for purposes other than obtaining insurance;

(c) Does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee);

(d) Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such members (or individuals eligible for coverage through a member); and

(e) Does not make health insurance coverage offered through the association available other than in connection with a member of the association.

(3) "COBRA continuation provision":

(a) Section 4980B of the Internal Revenue Code (26 U.S.C. Section 4980B), other than Subsection (f)(1) of that section as it relates to pediatric vaccines;

(b) Title I, Subtitle B, Part 6, excluding Section 609, of the Employee Retirement Income Security Act of 1974; or

(c) Title XXII of the Public Health Service Act, 42 U.S.C. Section 300dd, et seq.

(4) "Creditable coverage", coverage of the individual under any of the following:

(a) A group health plan;

(b) Health insurance coverage;

(c) Part A or Part B of Title XVIII of the Social Security Act ("Medicare");

(d) Title XIX of the Social Security Act ("Medicaid"), other than coverage consisting solely of benefits under section 1928 of such act (the program for distribution of pediatric vaccines);

(e) Chapter 55 of Title 10, United States Code (medical and dental care for members and certain former members of the uniformed services);

(f) A medical care program of the Indian Health Service or of a tribal organization;

(g) A state health benefits risk pool;

(h) A health plan offered under Title 5, Chapter 89, of the United States Code (the Federal Employees Health Benefits Program);

(i) A public health plan (established or maintained by the state or a political subdivision thereof providing health insurance coverage);

(j) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. Section 2504(3)).

Creditable coverage does not include coverage consisting solely of excepted benefits.

(5) "Enrollment date", with respect to an individual covered under a group health plan, the date of enrollment of the individual in the plan or, if earlier, the first day of the waiting period for enrollment.

(6) "Excepted benefits":

(a) Coverage only for accident (including accidental death and dismemberment) insurance;

(b) Coverage only for disability income insurance;

(c) Coverage issued as a supplement to liability insurance;

(d) Liability insurance, including general liability insurance and automobile liability insurance;

(e) Workers' compensation or similar insurance;

(f) Automobile medical payment insurance;

(g) Credit-only insurance;

(h) Coverage for onsite medical clinics;

(i) Other similar insurance coverage, as approved by the director, under which benefits for medical care are secondary or incidental to other insurance benefits;

(j) If provided under a separate policy, certificate or contract of insurance, any of the following:

a. Limited scope dental or vision benefits;

b. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;

c. Other similar, limited benefits as specified by the

director.

(k) If provided under a separate policy, certificate or contract of insurance, any of the following:

a. Coverage only for a specified disease or illness;

b. Hospital indemnity or other fixed indemnity insurance.

(l) If offered as a separate policy, certificate or contract of insurance, any of the following:

a. Medicare supplemental coverage (as defined under section 1882(g)(1) of the Social Security Act);

b. Coverage supplemental to the coverage provided pursuant to Chapter 55 of Title 10, United States Code (CHAMPUS supplemental programs);

c. Similar supplemental coverage provided to coverage under a group health plan.

(7) "Group health insurance coverage", health insurance coverage offered in connection with a group health plan or health insurance coverage offered to an eligible group as described in section 376.421;

(8) "Group health plan", an employee welfare benefit plan as defined in Section 3 of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care and items and services paid for as medical care to employees or their dependents, directly or through insurance, reimbursement, or otherwise, but not including excepted benefits;

(9) "Health insurance coverage", benefits consisting of medical care, including items and services paid for as medical care, that are provided directly, through insurance, reimbursement, or otherwise, under a policy, certificate, membership contract, or health services agreement offered by a health insurance issuer, but not including excepted benefits;

(10) "Health insurance issuer", an insurance company, health services corporation, fraternal benefit society, health maintenance organization, multiple employer welfare arrangement specifically authorized to operate in the state of Missouri, or any other entity providing a plan of health insurance or health benefits subject to state insurance regulation;

(11) "Individual health insurance coverage", health insurance coverage offered to individuals in the individual market, not including excepted benefits or short-term limited duration insurance;

(12) "Individual market", the market for health insurance coverage offered to individuals other than in connection with a group health plan;

(13) "Large employer", in connection with a group health plan, with respect to a calendar year and a plan year, an employer who employed an average of at least fifty-one employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year;

(14) "Large group market", the health insurance market under which individuals obtain health insurance coverage directly or through any arrangement on behalf of themselves and their dependents through a group health plan maintained by a large employer;

(15) "Late enrollee", a participant who enrolls in a group health plan other than during the first period in which the individual is eligible to enroll under the plan, or a special enrollment period pursuant to subsection 3 of section 376.450;

(16) "Medical care":

(a) The diagnosis, cure, mitigation, treatment, or prevention of disease or amounts paid for the purpose of affecting any structure or function of the body;

(b) Transportation primarily for and essential to medical care referred to in paragraph (a) of this subdivision; or

(c) Insurance covering medical care referred to in paragraphs (a) and (b) of this subdivision.

(17) "Network plan", health insurance coverage offered by a health insurance issuer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the issuer;

(18) "Participant", a person enrolled for coverage under a group health plan;

(19) "Plan sponsor", the entity described in Section 3 of the Employee Retirement Income Security Act of 1974;

(20) "Preexisting condition exclusion", with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date. Genetic information shall not be treated as a preexisting condition in the absence of a diagnosis of the condition related to such information;

(21) "Small group market", the health insurance market under which individuals obtain health insurance coverage directly or through an arrangement, on behalf of themselves and their dependents, through a group health plan maintained by a small employer as defined in subdivision (37) of section 379.930, RSMo;

(22) "Waiting period", with respect to a group health plan and an individual who is a potential participant in a group health plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the group health plan.

2. (1) No period of creditable coverage that occurs before a sixty-three day break in coverage during which the individual was not covered under any creditable coverage need be considered for purposes of paragraph (c) of subdivision (1) of subsection 5

of section 376.450.

(2) Any period of time that an individual is in a waiting period for coverage under group health insurance coverage, or is in an affiliation period, shall not be taken into account in determining whether a sixty-three day break under subdivision (1) of this subsection has occurred.

(3) Except as provided in subdivision (4) of this subsection, for the purposes of applying paragraph (c) of subdivision (1) of subsection 5 of section 376.450, a health insurance issuer offering group health insurance coverage shall count a period of creditable coverage without regard to the specific benefits included in the coverage.

(4) (a) A health insurance issuer offering group health insurance coverage may elect to apply the provisions of paragraph (c) of subdivision (1) of subsection 5 of section 376.450, based on coverage within any category of benefits within each of several classes or categories of benefits specified in regulations implementing Public Law 104-191, rather than as provided pursuant to subdivision (3) of this subsection. Such election shall be made on a uniform basis for all participants. Under such election a health insurance issuer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within the class or category.

(b) In the case of an election with respect to health insurance coverage offered by a health insurance issuer in the small or large group market pursuant to this subdivision, the health insurance issuer shall prominently state in any disclosure statements concerning the coverage, and prominently state to each employer at the time of the offer or sale of the coverage, that the issuer has made such election, and include in such statements a description of the effect of this election.

(5) Periods of creditable coverage with respect to an individual may be established through presentation of certifications and other means as specified in Public Law 104-191 and regulations pertinent thereto.

3. (1) A health insurance issuer offering group health insurance in connection with a group health plan shall permit an employee or a dependent of an employee who is eligible but not enrolled for coverage under the terms of the plan to enroll for coverage if:

(a) The employee or dependent was covered under a group health plan or had health insurance coverage at the time that coverage was previously offered to the employee or dependent;

(b) The employee stated in writing at the time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or health insurance issuer required the statement at the

time and provided the employee with notice of the requirement and the consequences of the requirement at the time;

(c) The employee's or dependent's coverage described in paragraph (a) of this subdivision was:

a. Under a COBRA continuation provision and was exhausted; or

b. Not under a COBRA continuation provision and was terminated as a result of loss of eligibility for the coverage or because employer contributions toward the cost of coverage were terminated; and

(d) Under the terms of the group health plan, the employee requests the enrollment not later than thirty days after the date of exhaustion of coverage described in subparagraph a. of paragraph (c) of this subdivision or termination of coverage or employer contributions described in subparagraph b. of paragraph (c) of this subdivision.

(2) (a) A group health plan shall provide for a dependent special enrollment period described in paragraph (b) of this subdivision during which an employee who is eligible but not enrolled and a dependent may be enrolled under the group health plan and, in the case of the birth or adoption of a child, the spouse of the employee may be enrolled as a dependent if the spouse is otherwise eligible for coverage.

(b) A dependent special enrollment period pursuant to this

subdivision is a period of not less than thirty days that begins on the date of the marriage, birth, or adoption or placement for adoption.

(3) The coverage becomes effective:

(a) In the case of marriage, not later than the first day of the first month beginning after the date on which the completed request for enrollment is received;

(b) In the case of a dependent's birth, as of the date of birth; or

(c) In the case of a dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

4. A health insurance issuer offering group health insurance coverage shall provide a certification of creditable coverage as required by Public Law 104-191 and regulations pertinent thereto.

5. (1) A health insurance issuer offering group health insurance coverage may with respect to a participant impose a preexisting condition exclusion if:

(a) Such exclusion relates to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date;

(b) Such exclusion extends for a period of not more than

twelve months (or eighteen months in the case of a late enrollee) after the enrollment date; and

(c) The period of any such preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage, if any, applicable to the participant as of the enrollment date.

(2) A health insurance issuer offering group health insurance coverage may not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the thirty-day period beginning with the date of birth, is covered under creditable coverage.

(3) Subject to subdivision (5) of this subsection, a health insurance issuer offering group health insurance coverage may not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining eighteen years of age and who, as of the last day of the thirty-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. The previous sentence shall not apply to coverage before the date of such adoption or placement for adoption.

(4) A health insurance issuer offering group health insurance coverage may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.

(5) Subdivisions (2) and (3) of this subsection shall no

longer apply to an individual after the end of the first sixty-three-day period during all of which the individual was not covered under any creditable coverage.

(6) In the case of group health insurance coverage offered by a health maintenance organization, the plan may provide for an affiliation period with respect to coverage through the organization only if:

(a) No preexisting condition exclusion is imposed with respect to coverage through the organization;

(b) The period is applied uniformly without regard to any health status-related factors;

(c) Such period does not exceed two months (or three months in the case of a late enrollee);

(d) Such period begins on the enrollment date; and

(e) Such period runs concurrently with any waiting period.

376.451. 1. (1) A health insurance issuer offering group health insurance coverage may not establish rules for eligibility, including continued eligibility, of any individual to enroll under the terms of the group health plan based on any of the following health status-related factors of the individual or a dependent of the individual:

(a) Health status;

(b) Medical condition, including both physical and mental illness;

(c) Claims experience;

(d) Receipt of health care;

(e) Medical history;

(f) Genetic information;

(g) Evidence of insurability, including conditions arising out of acts of domestic violence; or

(h) Disability.

(2) This subsection does not require a health insurance issuer offering group health insurance coverage to provide particular benefits other than those provided under the terms of the group health insurance coverage, or prevent the issuer from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the group health insurance coverage.

(3) For purposes of subdivision (1) of this subsection, rules for eligibility to enroll include rules defining any applicable waiting or affiliation period for such enrollment, and rules relating to late and special enrollments.

2. (1) A health insurance issuer offering health insurance coverage in connection with a group health plan may not require any individual, as a condition of enrollment or continued enrollment under the plan, to pay a premium or contribution that is greater than the premium or contribution for a similarly

situated individual enrolled in the group health plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.

(2) Nothing in subdivision (1) of this subsection shall be construed to:

(a) Restrict the amount that any employer may be charged for coverage under a group health plan; or

(b) Prevent a health insurance issuer offering group health insurance coverage, from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

376.452. 1. Except as provided in this section, if a health insurance issuer offers health insurance coverage in the large group market in connection with a group health plan, the health insurance issuer shall renew or continue the coverage in force at the option of the plan sponsor.

2. A health insurance issuer may nonrenew or discontinue health insurance coverage offered in connection with a group health plan in the large group market if:

(1) The plan sponsor has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or if the health insurance issuer has not

received timely premium payments;

(2) The plan sponsor has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of material fact in connection with the coverage;

(3) The plan sponsor has failed to comply with the health insurance issuer's minimum participation requirements;

(4) The plan sponsor has failed to comply with the health insurance issuer's employer contribution requirements;

(5) The health insurance issuer is ceasing to offer coverage in that group market in accordance with this section;

(6) In the case of a health insurance issuer that offers health insurance coverage in the group market through a network plan, there is no longer any enrollee under the group health plan who lives, resides, or works in the service area of the health insurance issuer;

(7) In the case of health insurance coverage that is made available in the small group market or large group market only through one or more bona fide associations, the membership of an employer in the bona fide association ceases, but only if coverage is terminated pursuant to this subdivision uniformly without regard to any health status-related factor of any covered individual.

3. A health insurance issuer may not discontinue offering a particular type of group health insurance coverage offered in the

large group market unless:

(1) The issuer provides notice to each plan sponsor and participant provided coverage of this type in that group market of the discontinuation at least ninety days prior to the date of the discontinuation of the coverage;

(2) The issuer offers to each plan sponsor provided coverage of this type in the market the option to purchase any other health insurance coverage currently being offered by the health insurance issuer to a group health plan in the market; and

(3) The issuer acts uniformly without regard to the claims experience of those plan sponsors or any health status-related factor of any participant covered or new participant who may become eligible for such coverage.

4. (1) A health insurance issuer may not discontinue offering all health insurance coverage in the large group market unless:

(a) The issuer provides notice of discontinuation to the director and to each plan sponsor and participant covered at least one hundred eighty days prior to the date of the discontinuation of coverage; and

(b) All health insurance issued or delivered for issuance in Missouri in the large group market is discontinued and coverage under such health insurance is not renewed.

(2) In the case of a discontinuation pursuant to this

subsection, the health insurance issuer may not provide for the issuance of any health insurance coverage in the large group market for a period of five years beginning on the date of the discontinuation of the last health insurance coverage not renewed.

5. At the time of coverage renewal a health insurance issuer may modify the health insurance coverage for a product offered to a group health plan in the large group market.

6. In the case of health insurance coverage that is made available by a health insurance issuer only through one or more bona fide associations, references to "plan sponsor" in this section is deemed, with respect to coverage provided to an employer member of the association, to include a reference to such employer.

376.771. 1. Except as provided in this section, a health insurance issuer that provides individual health insurance coverage to an individual shall renew or continue in force such coverage at the option of the individual.

2. A health insurance issuer may nonrenew or discontinue health insurance coverage of an individual in the individual market based only on one or more of the following:

(1) The individual has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the issuer has not received timely premium

payments;

(2) The individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage;

(3) The issuer is ceasing to offer coverage in the individual market in accordance with subsection 4 of this section;

(4) In the case of a health insurance issuer that offers health insurance coverage in the market through a network plan, the individual no longer resides, lives, or works in the service area (or in an area for which the issuer is authorized to do business) but only if such coverage is terminated pursuant to this subdivision uniformly without regard to any health status-related factor of covered individuals;

(5) In the case of health insurance coverage that is made available in the individual market only through one or more bona fide associations, the membership of the individual in the association (on the basis of which the coverage is provided) ceases, but only if such coverage is terminated pursuant to this subdivision uniformly without regard to any health status-related factor of covered individuals.

3. In any case in which an issuer decides to discontinue offering a particular type of health insurance coverage offered in the individual market, coverage of such type may be

discontinued by the issuer only if:

(1) The issuer provides notice to each covered individual provided coverage of this type in such market of such discontinuation at least ninety days prior to the date of the discontinuation of such coverage;

(2) The issuer offers to each individual in the individual market provided coverage of this type, the option to purchase any other individual health insurance coverage currently being offered by the issuer for individuals in such market; and

(3) In exercising the option to discontinue coverage of this type and in offering the option of coverage pursuant to subdivision (2) of this subsection, the issuer acts uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for such coverage.

4. (1) In any case in which a health insurance issuer elects to discontinue offering all health insurance coverage in the individual market in the state, health insurance coverage may be discontinued by the issuer only if:

(a) The issuer provides notice to the director of the department of insurance and to each individual of such discontinuation at least one hundred eighty days prior to the date of the expiration of such coverage; and

(b) All health insurance issued or delivered for issuance

in the state in such market are discontinued and coverage under such health insurance coverage in such market is not renewed.

(2) In the case of a discontinuation pursuant to subdivision (1) of this subsection, the issuer shall not provide for the issuance of any health insurance coverage in the market and for a five-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

5. At the time of coverage renewal, a health insurance issuer may modify the health insurance coverage for a policy form offered to individuals in the individual market so long as such modification is consistent with applicable law and effective on a uniform basis among all individuals with that policy form.

6. In applying this section in the case of health insurance coverage that is made available by a health insurance issuer in the individual market to individuals only through one or more associations, a reference to an individual is deemed to include a reference to such an association of which the individual is a member.

376.794. An insurer shall provide a certification of creditable coverage as required by Public Law 104-191 and regulations promulgated thereunder.

376.816. 1. No individual or group insurance policy providing coverage on an expense-incurred basis, no individual or

group service or indemnity contract issued by a not-for-profit health services corporation, no health maintenance organization nor any self-insured group health benefit plan of any type or description shall be offered, issued or renewed in this state on or after July 10, 1991, unless the policy, plan or contract covers adopted children of the insured, subscriber or enrollee on the same basis as other dependents.

2. The coverage required by subsection 1 of this section is effective:

(1) From the date of birth if a petition for adoption is filed within thirty days of the birth of such child; or

(2) From the date of placement for the purpose of adoption if a petition for adoption is filed within thirty days of placement of such child. Such coverage shall continue unless the placement is disrupted prior to legal adoption and the child is removed from placement. Coverage shall include the necessary care and treatment of medical conditions existing prior to the date of placement.

3. As used in this section, "placement" means **[**in the physical custody of the adoptive parent**]** the assumption and retention by the insured, subscriber or enrollee of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal

obligation.

376.960. As used in sections 376.960 to 376.989, the following terms mean:

(1) "Benefit plan", the coverages to be offered by the pool to eligible persons pursuant to the provisions of section 376.986;

(2) "Board", the board of directors of the pool;

(3) "Church plan", a plan as defined in Section 3(33) of the Employee Retirement Income Security Act of 1974;

(4) "Director", the director of the Missouri department of insurance;

[(4)**]** (5) "Department", the Missouri department of insurance;

(6) "Federally defined eligible individual", an individual:

(a) For whom, as of the date on which the individual seeks coverage through the pool, the aggregate of the periods of creditable coverage as defined in subdivision (4) of section 376.450, is eighteen or more months and whose most recent prior creditable coverage was under a group health plan as defined in subdivision (8) of subsection 1 of section 376.450, governmental plan as defined in Section 3(32) of the Employee Retirement Income Security Act of 1974, church plan, or health insurance coverage offered in connection with any such plan;

(b) Who is not eligible for coverage under a group health

plan, Part A or Part B of Title XVIII of the Social Security Act, or state plan under Title XIX of such act;

(c) Who does not have other health insurance coverage;

(d) For whom the most recent coverage within the coverage period described in paragraph (a) of this subdivision was not terminated because of nonpayment of premiums or fraud;

(e) Who, if offered the option of continuation coverage under COBRA continuation provision as defined in subdivision (3) of subsection 1 of section 376.450, or under a similar state program, both elected and exhausted the continuation coverage.

[(5)**]** (7) "Health insurance", any hospital and medical expense incurred policy, nonprofit health care service for benefits other than through an insurer, nonprofit health care service plan contract, health maintenance organization subscriber contract, preferred provider arrangement or contract, or any other similar contract or agreement for the provisions of health care benefits. The term "health insurance" does not include short-term, accident, fixed indemnity, limited benefit or credit insurance, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance;

[(6)**]** (8) "Health maintenance organization", any person which undertakes to provide or arrange for basic and supplemental health care services to enrollees on a prepaid basis, or which meets the requirements of section 1301 of the United States Public Health Service Act;

[(7)**]** (9) "Hospital", a place devoted primarily to the maintenance and operation of facilities for the diagnosis, treatment or care for not less than twenty-four hours in any week of three or more nonrelated individuals suffering from illness, disease, injury, deformity or other abnormal physical condition; or a place devoted primarily to provide medical or nursing care for three or more nonrelated individuals for not less than twenty-four hours in any week. The term "hospital" does not include convalescent, nursing, shelter or boarding homes, as defined in chapter 198, RSMo;

[(8)**]** (10) "Insurance arrangement", any plan, program, contract or other arrangement under which one or more employers, unions or other organizations provide to their employees or members, either directly or indirectly through a trust or third party administration, health care services or benefits other than through an insurer;

[(9)**]** (11) "Insured", any individual resident of this state who is eligible to receive benefits from any insurer or insurance arrangement, as defined in this section;

[(10)**]** (12) "Insurer", any insurance company authorized to transact health insurance business in this state, any nonprofit health care service plan act, or any health maintenance organization;

[(11)**]** (13) "Medicare", coverage **[**under**]** pursuant to both Part A and Part B of Title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq., as amended;

[(12)**]** (14) "Member", all insurers and insurance arrangements participating in the pool;

[(13)**]** (15) "Physician", physicians and surgeons licensed under chapter 334, RSMo, or by state board of healing arts in the state of Missouri;

[(14)**]** (16) "Plan of operation", the plan of operation of the pool, including articles, bylaws and operating rules, adopted by the board pursuant to the provisions of sections 376.961, 376.962 and 376.964;

[(15)**]** (17) "Pool", the state health insurance pool created in sections 376.961, 376.962 and 376.964.

376.966. 1. No employee shall involuntarily lose his or her group coverage by decision of his or her employer on the grounds that such employee may subsequently enroll in the pool. The department of insurance shall have authority to promulgate rules and regulations to enforce this subsection.

2. An individual person shall be eligible for benefit plan

coverage if the individual either is and continues to be a resident of this state or is legally domiciled in this state on the date the individual applies for pool coverage and has been certified as eligible for federal trade adjustment assistance or for pension benefit guarantee corporation assistance, as provided by the federal Trade Adjustment Assistance Reform Act of 2002, and the applicant provides evidence of the following:

(1) That such individual person is a federally defined individual, as defined in section 376.960; or

(2) A notice of rejection or refusal to issue substantially similar insurance for health reasons by one insurer; or

(3) A refusal by an insurer to issue insurance except at a rate exceeding one hundred fifty percent of the standard risk rate calculated pursuant to subsection 4 of section 376.986.

3. Any individual who is a resident of this state and not otherwise eligible pursuant to subsection 1 of this section shall be eligible for pool coverage, except the following:

(1) Persons who have, on the date of issue of coverage by the pool, coverage under health insurance or an insurance arrangement except that this exclusion shall not apply to:

(a) A person who has such coverage but whose premiums have increased to **[**three hundred**]** one hundred fifty percent or more of rates established by the board as applicable for individual standard risks; or

(b) A person who is certified as eligible under the federal Trade Adjustment Assistance Reform Act of 2002 and has three months of prior creditable coverage as described in subdivision (4) of subsection 1 of section 376.450;

(2) Any person who is at the time of pool application receiving health care benefits under section 208.151, RSMo;

(3) [Any person having terminated coverage in the pool unless twelve months have elapsed since such termination;

(4) Any person on whose behalf the pool has paid out one million dollars in benefits;

(5)] Inmates of public institutions and persons eligible for public programs;

[(6) Any person whose medical condition which precludes other insurance coverage is directly due to alcohol or drug abuse or self-inflicted injury;

(7)] (4) Any person who is eligible for continuation or conversion of insurance coverage under 29 U.S.C. 1161 to 29 U.S.C. 1168, 42 U.S.C. 300bb-1 to 42 U.S.C. 300bb-8, sections 376.395 to 376.404, or section 376.428, except that this exclusion shall not apply to a person who has such coverage but whose premiums have increased to [three] one hundred fifty percent or more of rates established by the board as applicable for individual standard risks; or

[(8)] (5) Any person who is eligible for Medicare coverage.

[3.**]** 4. Any person who ceases to meet the eligibility requirements of this section or maintain residency in this state may be terminated at the end of **[**his**]** such person's policy period.

[4.**]** 5. Any person whose health insurance coverage is involuntarily terminated for any reason other than nonpayment of premium or any person whose premiums have increased to **[**three hundred**]** one hundred fifty percent or more of rates established by the board as applicable for individual standard risks, may apply for coverage under the plan. If such coverage is applied for within sixty days after the involuntary termination and the application is approved and if premiums are paid for the entire coverage period, the effective date of the coverage shall be the date of termination of the previous coverage.

6. (1) If an insurer issues one or more of the following or takes any other action based wholly or partially on medical underwriting considerations which is likely to render any person eligible for pool coverage, the insurer shall notify all persons affected of the existence of the pool, as well as the eligibility requirements and methods of applying for pool coverage:

(a) A notice of rejection or cancellation of coverage;

(b) A notice of reduction or limitation of coverage, including restrictive riders, if the effect of the reduction or limitation is to substantially reduce coverage compared to the

coverage available to a person considered a standard risk for the type of coverage provided by the plan;

(c) A notice of increase in premium to an amount exceeding the premium then in effect for pool coverage having the same or similar deductible for a person of the same age, sex, and geographical location;

(d) A notice of premium for coverage not yet in effect which exceeds the premium then in effect for pool coverage having the same or similar deductible for a person of the same age, sex, and geographical location.

(2) Any notice issued under subdivision (1) of this subsection shall also state the reasons for the rejection, termination, cancellation, or imposition of underwriting restrictions.

376.975. Each member's proportion of participation in the pool shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed by the member with it. Any deficit incurred by the pool shall be recouped by assessments apportioned as provided in subsections 1, 2, and 3 of section 376.973 by the board among members. The amount of assessments incurred by each member of the pool shall be allowed as an offset against certain taxes, and shall be subject to certain limitations, as follows: Each pool member subject to chapter 148, RSMo, may deduct from premium

taxes payable for any calendar year to the state any and all assessments paid for the same year pursuant to sections 376.960 to 376.989; provided, however, that assessments paid for calendar year 2005 may only be deducted from premium taxes payable for calendar year 2008, assessments paid for calendar year 2006 may only be deducted from premium taxes payable for calendar year 2009, and assessments paid for calendar year 2007 may only be deducted from premium taxes payable for calendar year 2010. All assessments, for a fiscal year, shall not exceed the net premium tax due and payable by such member in the previous year. If the assessment exceeds any premium tax due or payable in such year, including calendar years 2008, 2009, and 2010, the excess shall be a credit or offset carried forward against any premium tax due or payable in succeeding years until the excess is exhausted.

376.986. 1. The pool shall offer major medical expense coverage to every person eligible for coverage under section 376.966. The coverage to be issued by the pool and its schedule of benefits, exclusions and other limitations, shall be established by the board with the advice and recommendations of the pool members, and such plan of pool coverage shall be submitted to the director for approval. The pool shall also offer coverage for drugs and supplies requiring a medical prescription and coverage for patient education services, to be provided at the direction of a physician, encompassing the

provision of information, therapy, programs, or other services on an inpatient or outpatient basis, designed to restrict, control, or otherwise cause remission of the covered condition, illness or defect.

2. In establishing the pool coverage the board shall take into consideration the levels of health insurance provided in this state and medical economic factors as may be deemed appropriate, and shall promulgate benefit levels, deductibles, coinsurance factors, exclusions and limitations determined to be generally reflective of and commensurate with health insurance provided through a representative number of insurers in this state.

3. Premiums charged for pool coverage may not be unreasonable in relation to the benefits provided, the risk experience and the reasonable expenses of providing the coverage. Separate schedules of premium rates based on age, sex and geographical location may apply for individual risks.

4. The pool shall determine the standard risk rate by calculating the average individual standard rate charged by the five insurers with the largest number of individual contracts in force. In the event five insurers do not offer comparable coverage, the standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for such coverage. Initial rates for

pool coverage shall not be less than one hundred fifty percent of rates established as applicable for individual standard risks. Subsequent rates shall be established to provide fully for the expected costs of claims including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described herein. In no event shall pool rates exceed **[**two hundred percent of rates applicable to individual standard risks**]** the following:

(1) For federally defined eligible individuals, rates shall be equal to the percent of rates applicable to individual standard risks actuarially determined to be sufficient to recover the sum of the cost of benefits paid under the pool for federally defined eligible individuals plus the proportion of the pool's administrative expense applicable to federally defined eligible individuals enrolled for pool coverage, provided that such rates shall not exceed one hundred fifty percent of rates applicable to individual standard risks; and

(2) For all other individuals covered under the pool, one hundred fifty percent of rates applicable to individual standard risks.

All rates and rate schedules shall be submitted to the director for approval.

5. Pool coverage established pursuant to this section shall

provide an appropriate high and low deductible to be selected by the pool applicant. The deductibles and coinsurance factors may be adjusted annually in accordance with the medical component of the consumer price index.

6. Pool coverage shall exclude charges or expenses incurred during the first twelve months following the effective date of coverage as to any condition which, during the six-month period immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek diagnosis, care or treatment or for which medical advice, care or treatment was recommended or received as to such condition. Such preexisting condition exclusions shall be waived as follows:

(1) To the extent to which similar exclusions, if any, have been satisfied under any prior health insurance coverage which was involuntarily terminated, if that application for pool coverage is made not later than **[**six**]** sixty-three days following such involuntary termination and, in such case, coverage in the pool shall be effective from the date on which such prior coverage was terminated; and

(2) In the case of a person who has been certified as eligible for federal trade provided by the federal Trade Adjustment Assistance Reform Act of 2002, if the person maintained creditable health insurance coverage for an aggregate

period of three months prior to loss of employment with no gap in coverage greater than sixty-three days.

7. Benefits otherwise payable under pool coverage shall be reduced by all amounts paid or payable through any other health insurance, or insurance arrangement, and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment or liability insurance whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program except Medicaid. The insurer or the pool shall have a cause of action against an eligible person for the recovery of the amount of benefits paid which are not for covered expenses. Benefits due from the pool may be reduced or refused as a setoff against any amount recoverable under this subsection.

8. Medical expenses shall include expenses for comparable benefits for those who rely solely on spiritual means through prayer for healing.

376.995. 1. This section shall be known as the "Limited Mandate Health Insurance Act".

2. Limited mandate health insurance policies and contracts shall mean those policies and contracts of health insurance as defined in section 376.960 and which cover individuals and their families (but not including any Medicare supplement policy or

contract) and groups sponsored by an employer who employs fifty or fewer persons.

3. Notwithstanding any other provision of law to the contrary, no law requiring the coverage of a particular health care service or benefit, or requiring the reimbursement, utilization or inclusion of a specific category of licensed health care practitioner, shall apply to limited mandate health insurance policies and contracts[, except the following provisions:

(1) Subsection 1 of section 354.095, RSMo, to the extent that it regulates maternity benefits;

(2) Section 375.995, RSMo;

(3) Section 376.406;

(4) Section 376.428;

(5) Section 376.782;

(6) Section 376.816;

(7) Section 376.1210;

(8) Section 376.1215; and

(9) Section 376.1219]. The requirements contained in this section for benefits provided under limited mandate health insurance policies and contracts shall be the exclusive requirements for such policies and contracts.

4. In order for an insurer as defined in section 376.960 to be eligible to market, sell or issue limited mandate health

insurance, the insurer shall:

(1) [Restrict its marketing and sales efforts to only those persons or groups as defined in subsection 2 of this section which currently do not have health insurance coverage or to those persons or employers which certify in writing to the insurer that they will terminate the coverage they currently have at the time they would otherwise renew coverage because of cost;

(2)] Fully and clearly disclose to the person or group to whom the limited mandate health insurance policy or contract is to be issued that the reason coverage for this product is less expensive than other coverage is because the policy or contract does not contain coverages or health professional payment mechanisms that are required by subsection 3 of this section;

[(3)] (2) Clearly disclose in all sales, promotional and advertising material related thereto that the product is a limited mandate health insurance policy or contract.

5. The provisions of section 376.441 shall not apply to any group which replaces its current coverage with a limited mandate health insurance policy or contract if the benefit to be extended is one for services which are not covered by the replacing policy or contract.

6. Notwithstanding any other provision of this section to the contrary, the provisions of paragraph (b) of subdivision (11) of section 375.936, RSMo, shall apply to limited mandate health

insurance policies with respect to physician services covered under such policies, which can be provided by persons licensed pursuant to section 332.181, RSMo.

376.1578. As used in sections 376.1578 to 376.1593, unless otherwise specifically provided, the following terms shall mean:

(1) "Appropriate committees of the general assembly" or "committees", standing committees of the Missouri state senate and house of representatives that have jurisdiction over issues that regulate health carriers, health care facilities, health care providers, or health care services;

(2) "Health carrier" or "carrier" shall have the same meaning as ascribed in section 376.1350;

(3) "Mandated health benefit", "mandated benefit", or "benefit", coverage or offering required by law to be provided by a health carrier to:

(a) Cover a specific health care service or services;

(b) Cover treatment of a specific condition or conditions; or

(c) Contract, pay, or reimburse specific categories of health care providers for specific services; a mandated option is not a mandated health benefit;

(4) "Mandated benefit review commission", the commission established pursuant to section 376.1581.

376.1581. 1. There is hereby established a commission to

be known as the "Mandated Health Benefit Review Commission" within the department of insurance. The commission shall consist of the following members:

(1) The director of the department of insurance who shall serve in a nonvoting advisory capacity;

(2) The director of the department of health and senior services who shall serve in a nonvoting advisory capacity;

(3) Two members of the Missouri house of representatives, one from each major political party represented in the house of representatives, appointed by the speaker of the house who shall serve in a nonvoting advisory capacity;

(4) Two members of the senate, one from each major political party represented in the senate, appointed by the president pro tem of the senate who shall serve in a nonvoting advisory capacity;

(5) One member representing the interests of employers having more than one hundred employees, appointed by the governor with the advice and consent of the senate;

(6) One member representing the interests of employers having less than one hundred employees, appointed by the governor with the advice and consent of the senate;

(7) Two individual purchasers of health insurance policies, appointed by the governor with the advice and consent of the senate; and

(8) Two employees that pay a percentage of their health insurance sponsored by their employers, appointed by the governor with the advice and consent of the senate.

2. Members appointed by the governor shall serve for four-year terms and until their successors are appointed; provided however, that the terms of half of the six original appointees shall be for two years. Other members, except legislative members, shall serve for as long as they hold the position which made them eligible for appointment. Legislative members shall serve during their current term of office but may be reappointed.

3. Members of the commission shall not be compensated for their services, but may be reimbursed for actual and necessary expenses incurred in the performance of their duties. The office of administration and the departments of health and insurance shall provide such support as the commission requires to aid it in the performance of its duties. The commission may consult with experts from the health research, biostatistics, actuarial science and other areas the commission deems appropriate.

4. The members appointed by the governor shall be residents of Missouri. Any vacancy on the commission shall be filled in the same manner as the original appointment.

5. The commission shall be established by October 1, 2003.

376.1584. 1. After the mandated health benefit review

commission has been established pursuant to section 376.1581, the commission shall review all existing state health care mandates and issue a report to the president pro tem of the senate, the speaker of the house of representatives, and the respective committees in both houses which handle health and insurance issues. The commission shall review the projected costs of all existing state and federal mandated benefits. The report shall state the costs of all current state and federal mandated benefits and recommend to the general assembly which mandated benefits should be repealed from state law.

2. The commission shall submit the list of the proposed deletions of state mandated benefits to the general assembly no later than the tenth legislative day of the session beginning in January 2006. Upon submittal, the general assembly may introduce legislation implementing the recommendations of the mandated benefit review commission.

376.1587. If a legislative measure contains a mandated health benefit, the appropriate committee of the general assembly having jurisdiction over the proposal shall hold a public hearing and determine the level of support for the proposal among the members of the committee. If there is support for the proposed mandate among a majority of the members of the committee, the committee may refer the proposal to the mandated health benefit review commission for review and evaluation pursuant to sections

376.1590 and 376.1593. Upon completion of a review and evaluation, the committee shall review the findings of the mandated health benefit review commission. No mandated health benefit shall be enacted into law prior to January 1, 2007, and after such date, no proposed mandate shall be enacted into law unless review and evaluation pursuant to sections 376.1590 and 376.1593 has been completed.

376.1590. Every proposed legislative measure that mandates a health insurance coverage, whether by requiring payment for certain providers or by requiring an offering of a health insurance coverage by an insurer or health carrier as a component of individual or group health insurance policies, shall be accompanied by a report prepared by the mandated health benefit review commission that assesses both the social and financial effects of the coverage in the manner provided in section 376.1593, including the efficacy of the treatment or service proposed.

376.1593. Upon referral of a mandated health benefit proposal from the appropriate committee of the general assembly having jurisdiction over the proposal, the mandated health benefit review commission shall conduct a review and evaluation of the mandated health benefit proposal and shall report to the committee in a timely manner. The report shall include, at the minimum and to the extent that information is available, the

following:

(1) The social impact of mandating the benefit, including:

(a) The extent to which the treatment or service is utilized by a significant portion of the population;

(b) The extent to which the treatment or service is available to the population;

(c) The extent to which insurance coverage for this treatment or service is already available;

(d) If coverage is not generally available, the extent to which the lack of coverage results in persons being unable to obtain necessary health care treatment;

(e) If the coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship on those persons needing treatment;

(f) The level of public demand and the level of demand from providers for the treatment or service;

(g) The level of public demand and the level of demand from the providers for individual or group insurance coverage of the treatment or service;

(h) The level of interest in and the extent to which collective bargaining organizations are negotiating privately for inclusion of this coverage in group contracts;

(i) The likelihood of achieving the objectives of meeting a consumer need as evidenced by the experience of other states;

(j) The relevant findings of the state health planning agency or the appropriate health system agency relating to the social impact of the mandated benefit;

(k) The alternatives to meeting the identified need;

(l) Whether the benefit is a medical or a broader social need and whether it is consistent with the role of health insurance and the concept of managed care;

(m) The impact of any social stigma attached to the benefit upon the market;

(n) The impact of this benefit on the availability of other benefits currently being offered;

(o) The impact of the benefit as it relates to employers shifting to self-insured plans and the extent to which the benefit is currently being offered by employers with self-insured plans; and

(p) The impact of making the benefit applicable to the state employee health insurance program established pursuant to chapter 103, RSMo;

(2) The financial impact of mandating the benefit, including:

(a) The extent to which the proposed insurance coverage would increase or decrease the cost of the treatment or service over the next five years;

(b) The extent to which the proposed coverage may increase

the appropriate or inappropriate use of the treatment or service over the next five years;

(c) The extent to which the mandated treatment or service may serve as an alternative for more expensive or less expensive treatment or service;

(d) The methods that will be instituted to manage the utilization and costs of the proposed mandate;

(e) The extent to which the insurance coverage may affect the number and types of providers of the mandated treatment or service over the next five years;

(f) The extent to which insurance coverage of the health care service or provider may be reasonably expected to increase or decrease the insurance premium and administrative expenses of policyholders;

(g) The impact of indirect costs, which are costs other than premiums and administrative costs, on the question of the costs and benefits of coverage;

(h) The impact of this coverage on the total cost of health care, including potential benefits and savings to insurers and employers because the proposed mandated treatment or service prevents disease or illness or leads to the early detection and treatment of disease or illness that is less costly than treatment or service for later stages of a disease or illness;

(i) The effects of mandating the benefit on the cost of

health care, particularly the premium and administrative expenses and indirect costs, to employers and employees, including the financial impact on small employers, medium-sized employers and large employers; and

(j) The effect of the proposed mandate on cost-shifting between private and public payors of health care coverage and on the overall cost of the health care delivery system in this state;

(3) The medical efficacy of mandating the benefit, including:

(a) The contribution of the benefit to the quality of patient care and the health status of the population, including the results of any research demonstrating the medical efficacy of the treatment or service compared to alternatives or not providing the treatment or service; and

(b) If the legislation seeks to mandate coverage of an additional class of practitioners:

a. The results of any professionally acceptable research demonstrating the medical results achieved by the additional class of practitioners relative to those already covered; and

b. The methods of the appropriate professional organization that assure clinical proficiency; and

(4) The effects of balancing the social, economic and medical efficacy considerations, including:

(a) The extent to which the need for coverage outweighs the costs of mandating the benefit for all policyholders;

(b) The extent to which the problem of coverage may be solved by mandating the availability of the coverage as an option for policyholders; and

(c) The cumulative impact of mandating this benefit in combination with existing mandates on the costs and availability of coverage.

376.1600. Any health carrier, as defined in section 376.1350, providing group health insurance plans or group health benefits to an employer having a group of twenty-five employees or more shall, upon request by the employer or the employer's agent of record, provide a state of the annual claims history for each of the prior three years, or the total experience if the coverage has been in effect less than three years. The information shall be provided within thirty days of such request and shall include the total aggregate amount of claims paid and the total number of claims filed for each annual period. The information may be used by the employer or the employer's agent of record for the sole purpose of evaluating and marketing the group insurance program. The information provided to the employer or the employer's agent of record shall be furnished in a manner that does not individually identify an employee or an employee's family member and shall comply with all applicable

federal and state privacy laws regarding the disclosure of health records.

379.110. As used in sections 379.110 to 379.120 the following words and terms mean:

(1) "Insurer" [means], any insurance company, association or exchange authorized to issue policies of automobile insurance in the state of Missouri[.];

(2) "Nonpayment of premium" [means], failure of the named insured to discharge when due any of his or her obligations in connection with the payment of premiums on a policy, or any installment of such premium, whether the premium is payable directly to the insurer or its agent or indirectly under any premium finance plan or extension of credit[.];

(3) "Policy" [means], an automobile policy providing automobile liability coverage, uninsured motorists coverage, automobile medical payments coverage, or automobile physical damage coverage insuring a private passenger automobile owned by an individual or partnership which has been in effect for more than sixty days or has been renewed. "Policy" does not mean:

(a) Any policy issued under an automobile assigned risk plan or automobile insurance plan;

(b) Any policy insuring more than four motor vehicles;

(c) Any policy covering the operation of a garage, automobile sales agency, repair shop, service station or public

parking place;

(d) Any policy providing insurance only on an excess basis, or to any contract principally providing insurance to such named insured with respect to other than automobile hazards or losses even though such contract may incidentally provide insurance with respect to such motor vehicles**[**.**]**;

(4) "Renewal" or "to renew" **[**means**]**, the issuance and delivery by an insurer of a policy superseding at the end of the policy period a policy previously issued and delivered by the same insurer, such renewal policy to provide types and limits of coverage at least equal to those contained in the policy being superseded, or the issuance and delivery of a certificate or notice extending the term of a policy beyond its policy period or term with types and limits of coverage at least equal to those contained in the policy being extended; provided, however, that any policy with a policy period or term of less than **[**twelve**]** six months or any period with no fixed expiration date shall for the purpose of this section be considered as if written for successive policy periods or terms of **[**twelve**]** six months. Nothing in this subdivision shall be construed as superceding the provisions of subsection 9 of section 375.918, RSMo, and the term "third anniversary date of the initial contract", as used in subsection 9 of section 375.918, RSMo, means three years after the date of the initial contract.

379.815. As used in this section, the following terms mean:

(1) "All-industry placement facility" (hereinafter referred to as "the facility"), the organization formed by insurers to assist applicants in securing basic property insurance, to issue policies and to administer the program and the joint reinsurance association;

(2) "Basic property insurance", the coverage against direct loss to real and tangible personal property at a fixed location that is provided in the standard fire policy and extended coverage endorsement, including builders' risk, and such vandalism and malicious mischief endorsements, homeowner's insurance and such other classes of insurance as may be added to the program with respect to the property by amendment as hereinafter provided. Basic property insurance does not include automobile risks or such types of manufacturing risks as the governing committee may exclude with the approval of the director. Any contact, as defined in section 375.918, RSMo, of the facility shall be subject to the provisions of section 375.918, RSMo;

(3) "Commercial", basic property insurance not included under the personal lines statistical plan;

(4) "Director", the director of the department of insurance of the state of Missouri;

(5) "Habitational", basic property insurance included under

the personal lines statistical plan;

(6) "Inspection bureau", the rating bureau or other organization designated by the facility with the approval of the director to make inspections as required under the program and to perform such other duties as may be authorized by the facility;

(7) "Insurer", any insurance company, reciprocal or interinsurance exchange or other organization licensed and authorized by the director to write property insurance, including the property insurance components of multiperil policies, on a direct basis, in this state;

(8) "Person" includes any individual or group of individuals, corporation, partnership, or association, or any other organized group of persons;

(9) "Premiums written", gross direct premiums (excluding that portion of premium on risks ceded to the joint reinsurance association) charged during the second preceding calendar year with respect to property in this state on all policies of basic property insurance and the basic property insurance premium components of all multiperil policies, as computed by the facility, less return premiums, dividends paid or credited to policyholders, or the unused or unabsorbed portions of premium deposits;

(10) "Property owner", with respect to any real, personal, or mixed real and personal property, means any person having an

insurable interest in such property;

(11) "Secretary", the Secretary of the United States Department of Housing and Urban Development.

379.825. 1. The facility, upon receipt of an application for coverage and the corresponding inspection report from the inspection bureau, shall, after it finds that the property is eligible for insurance under this program, issue a policy.

2. The facility shall apportion the liability so assumed to the insurers in the manner hereinafter provided in section 379.835.

3. Assessments upon each insurer in the program for expenses in connection with program business shall be levied and assessed by the governing committee of the facility in the manner hereinafter provided in section 379.835, subject to such minimum assessment as shall be established by the governing committee.

4. Subject to the insurable value thereof, the maximum limits of liability which may be placed through this program are: on any habitational property at one location, **[**one**]** two hundred thousand dollars; and on any commercial property at one location, one million dollars. The facility will endeavor to assist in placement when the requested amount of insurance exceeds the maximum limit of liability available under this program. The word "location" as used herein means real and personal property consisting of and contained in a single building or consisting of

and contained in contiguous buildings under one ownership.

379.930. 1. Sections 379.930 to 379.952 shall be known and may be cited as the "Small Employer Health Insurance Availability Act".

2. For the purposes of sections 379.930 to 379.952, the following terms shall mean:

(1) "Actuarial certification" [means], a written statement by a member of the American Academy of Actuaries or other individual acceptable to the director that a small employer carrier is in compliance with the provisions of section 379.936, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans;

(2) "Affiliate" or "affiliated" [means], any entity or person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person;

(3) "Agent" means "insurance agent" as that term is defined in section 375.012, RSMo;

(4) "Base premium rate" [means], for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under the rating system for that class of business, by the small employer carrier to small employers with

similar case characteristics for health benefit plans with the same or similar coverage;

(5) [**"Basic health benefit plan" means a lower cost health benefit plan developed pursuant to section 379.944;

(6)**] "Board" [**means**], the board of directors of the program established pursuant to sections 379.942 and 379.943;

[**(7)**] (6) "Broker" means "broker" as that term is defined in section 375.012, RSMo;

[**(8)**] (7) "Carrier" [**means**], any entity that provides health insurance or health benefits in this state. For the purposes of sections 379.930 to 379.952, carrier includes an insurance company, health services corporation, fraternal benefit society, health maintenance organization, multiple employer welfare arrangement specifically authorized to operate in the state of Missouri, or any other entity providing a plan of health insurance or health benefits subject to state insurance regulation;

[**(9)**] (8) "Case characteristics" [**means**], demographic or other objective characteristics of a small employer that are considered by the small employer carrier in the determination of premium rates for the small employer, provided that claim experience, health status and duration of coverage since issue shall not be case characteristics for the purposes of sections 379.930 to 379.952;

[(10)**]** (9) "Class of business" **[**means**]**, all or a separate grouping of small employers established pursuant to section 379.934;

(10) "Church plan", the meaning given such term in Section 3(33) of the Employee Retirement Income Security Act of 1974;

(11) "Committee" **[**means**]**, the health benefit plan committee created pursuant to section 379.944;

(12) "Control" shall be defined in manner consistent with chapter 382, RSMo;

(13) "Creditable coverage", with respect to an individual:

(a) Coverage of the individual pursuant to any of the following:

a. A group health plan;

b. Health insurance coverage;

c. Part A or Part B of Title XVIII of the Social Security Act;

d. Title XIX of the Social Security Act, other than coverage consisting solely of benefits pursuant to Section 1928 of such act;

e. Chapter 55 of Title 10, United States Code;

f. A medical care program of the Indian Health Service or of a tribal organization;

g. A state health benefits risk pool;

h. A health plan offered pursuant to Chapter 89 of Title 5,

United States Code;

i. A public health plan, as defined in federal regulations authorized by Section 2701(c)(1)(I) of the Public Health Services Act, as amended by P.L. 104-191; and

j. A health benefit plan pursuant to Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e));

(b) Creditable coverage shall not include coverage consisting solely of excepted benefits;

(c) A period of creditable coverage shall not be counted, with respect to enrollment of an individual if, after such period and before the enrollment date, there was a sixty-three-day period during all of which the individual was not covered under any creditable coverage;

(14) "Dependent" **[**means**]**, a spouse or an unmarried child under the age of nineteen years; an unmarried child who is a full-time student under the age of twenty-three years and who is financially dependent upon the parent; or an unmarried child of any age who is medically certified as disabled and dependent upon the parent;

[(14)**]** (15) "Director" **[**means**]**, the director of the department of insurance of this state;

[(15)**]** (16) "Eligible employee" **[**means**]**, an employee who works on a full-time basis and has a normal work week of thirty or more hours. The term includes a sole proprietor, a partner of

a partnership, and an independent contractor, if the sole proprietor, partner or independent contractor is included as an employee under a health benefit plan of a small employer, but does not include an employee who works on a part-time, temporary or substitute basis. For purposes of sections 379.930 to 379.952, a person, his spouse and his minor children shall constitute only one eligible employee when they are employed by the same small employer;

[(16)**]** (17) "Established geographic service area" **[**means**]**, a geographical area, as approved by the director and based on the carrier's certificate of authority to transact insurance in this state, within which the carrier is authorized to provide coverage;

(18) "Excepted benefits":

(a) Coverage only for accident (including accidental death and dismemberment) insurance;

(b) Coverage only for disability income insurance;

(c) Coverage issued as a supplement to liability insurance;

(d) Liability insurance, including general liability insurance and automobile liability insurance;

(e) Workers' compensation or similar insurance;

(f) Automobile medical payment insurance;

(g) Credit-only insurance;

(h) Coverage for onsite medical clinics;

(i) Other similar insurance coverage, as approved by the director, under which benefits for medical care are secondary or incidental to other insurance benefits;

(j) If provided under a separate policy, certificate or contract of insurance, any of the following:

a. Limited scope dental or vision benefits;

b. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;

c. Other similar, limited benefits as specified by the director.

(k) If provided under a separate policy, certificate or contract of insurance, any of the following:

a. Coverage only for a specified disease or illness;

b. Hospital indemnity or other fixed indemnity insurance.

(l) If offered as a separate policy, certificate or contract of insurance, any of the following:

a. Medicare supplemental coverage (as defined under section 1882(g)(1) of the Social Security Act);

b. Coverage supplemental to the coverage provided pursuant to Chapter 55 of Title 10, United States Code (CHAMPUS supplemental programs);

c. Similar supplemental coverage provided to coverage under a group health plan.

[(17)**]** (19) "Government plan", the meaning given such term

pursuant to Section 3(32) of the Employee Retirement Income Security Act of 1974 or any federal government plan;

(20) "Group health plan", an employee welfare benefit plan as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care, as defined in this section, and including any item or service paid for as medical care to an employee or the employee's dependent, as defined under the terms of the plan, directly or through insurance, reimbursement or otherwise. For purposes of sections 379.930 to 379.952:

(a) Any plan, fund or program which would not be, but for this subdivision, an employee welfare benefit plan except pursuant to the provisions of this subdivision, and which is established or maintained by a partnership to the extent that such plan, fund or program provides medical care, including any item or service paid for as medical care to a present or former partner in such partnership, or to the partner's dependents, as defined under the terms of the plan, fund or program, directly or through insurance, reimbursement or otherwise, shall be treated, subject to paragraph (b) of this subdivision, as an employee welfare benefit plan which is a group health plan;

(b) In the case of a group health plan, the term "employer" also includes a partnership in relation to any partner; and

(c) In the case of a group health plan, the term

"participant" also includes:

a. In connection with a group health plan maintained by a partnership, an individual who is a partner in relation to a partnership; or

b. In connection with a group health plan maintained by a self-employed individual under which one or more employees are participants, the self-employed individual, if such individual is or may become eligible to receive a benefit under the plan or such individual's beneficiary may be eligible to receive any such benefit;

(d) Group health plan does not include excepted benefits;

(21) "Health benefit plan" **[**means**]**, any hospital or medical policy or certificate, health services corporation contract, or health maintenance organization subscriber contract. Health benefit plan does not include a policy of individual accident and sickness insurance, or hospital supplemental policies having a fixed daily benefit, or accident-only, specified disease-only, credit, dental, vision, Medicare supplement, long-term care, or disability income insurance, or coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, or automobile medical payment insurance;

(22) "Health status-related factor", any of the following:

(a) Health status;

(b) Medical condition, including both physical and mental

illnesses;

(c) Claims experience;

(d) Receipt of health care;

(e) Medical history;

(f) Genetic information;

(g) Evidence of insurability, including a condition arising out of an act of domestic violence;

(h) Disability;

[(18)**]** (23) "Index rate" **[**means**]**, for each class of business as to a rating period for small employers with similar case characteristics, the arithmetic mean of the applicable base premium rate and the corresponding highest premium rate;

[(19)**]** (24) "Late enrollee" **[**means**]**, an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period for which such individual is entitled to enroll under the terms of the health benefit plan, provided that such initial enrollment period is a period of at least thirty days. However, an eligible employee or dependent shall not be considered a late enrollee if:

(a) The individual meets each of the following:

a. The individual was covered under **[**qualifying previous**]** creditable coverage at the time of the initial enrollment;

b. The individual lost coverage under **[**qualifying previous**]** creditable coverage as a result of cessation of employer

contribution, termination of employment or eligibility, reduction in the number of hours of employment, the involuntary termination of the [qualifying previous] creditable coverage, death of a spouse [or divorce;], dissolution or legal separation; and

c. The individual requests enrollment within thirty days after termination of the [qualifying previous] creditable coverage;

(b) The individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period; or

(c) A court has ordered coverage be provided for a spouse or minor or dependent child under a covered employee's health benefit plan and request for enrollment is made within thirty days after issuance of the court order;

[(20)] (25) "Medical care", an amount paid for:

(a) The diagnosis, care, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body;

(b) Transportation primarily for and essential to medical care referred to in paragraph (a) of this subdivision; or

(c) Insurance covering medical care referred to in paragraphs (a) and (b) of this subdivision;

(26) "Network plan", a health benefit plan that requires an enrollee to use or creates incentives, including financial

incentives, for an enrollee to use, health care providers managed, owned, under contract with or employed by the health carrier;

(27) "New business premium rate" **[**means**]**, for each class of business as to a rating period, the lowest premium rate charged or offered, or which could have been charged or offered, by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage;

[(21)**]** (28) "Plan of operation" **[**means**]**, the plan of operation of the program established pursuant to sections 379.942 and 379.943;

[(22)**]** (29) "Plan sponsor", the meaning given such term pursuant to Section 3(16)(B) of the Employee Retirement Income Security Act of 1974;

(30) "Premium" **[**means**]**, all moneys paid by a small employer and eligible employees as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan;

[(23)**]** (31) "Producer" includes an insurance agent or broker;

[(24)**]** (32) "Professional association", an association which meets all of the following:

(a) Serves a single profession, if such profession requires

a significant amount of education, training or experience, or a license or certificate from a state authority to practice such profession;

(b) Has been actively in existence for five years;

(c) Has a constitution or bylaws, or any other analogous governing document;

(d) Has been formed and maintained in good faith for a purpose other than obtaining insurance;

(e) Is not owned or controlled by a carrier or affiliated with a carrier;

(f) Does not condition membership in the association on health status or claims experience;

(g) Has at least one thousand members if it is a national association; five hundred members if it is a state association; or two hundred members if it is a local association;

(h) Any member or dependent of a member is eligible for coverage regardless of health status or claims experience;

(i) Does not offer a health benefit plan to an individual through the association other than in connection with a member of the association;

(j) Is governed by a board of directors and sponsors annual meetings of its members; and

(k) Producers may only market an association membership, accept an application for membership, or sign up a member in the

professional association if such individual is actively engaged in, or directly related to, the profession represented by the professional association;

(33) "Professional association plan", a health benefit plan offered through a professional association that covers members of a professional association and their dependents in this state regardless of the situs of delivery of the policy or contract and meets the following:

(a) Conforms with the provisions of section 379.936 concerning the premium rates as they apply to an individual carrier and individual health benefit plan;

(b) Provides renewability of coverage for the members and dependents of members of a professional association which meets the requirements set forth in subsection 2 of section 379.938 as applied to an individual health benefit plan;

(c) Provides availability of coverage for the members and dependents of members of the professional association in conformance with the provisions of subdivisions (1), (2) and (3) of subsection 2 of section 379.940 as applied to an individual health benefit plan and individual carrier;

(d) Is offered by a carrier that offers health benefit plan coverage to any professional association seeking health benefit plan coverage from such carrier; and

(e) Conforms with the preexisting condition provisions of

subsection 2 of section 379.940 as applied to an individual health benefit plan;

(34) "Program" [means], the Missouri small employer health reinsurance program created pursuant to sections 379.942 and 379.943;

[(25) "Qualifying previous coverage" and "qualifying existing coverage" mean benefits or coverage provided under:

(a) Medicare or Medicaid;

(b) An employer-based health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic health benefit plan; or

(c) An individual health insurance policy (including coverage issued by a health maintenance organization, health services corporation or a fraternal benefit society) that provides benefits similar to or exceeding the benefits provided under the basic health benefit plan, provided that such policy has been in effect for a period of at least one year;

(26)] (35) "Rating period" [means], the calendar period for which premium rates established by a small employer carrier are assumed to be in effect;

[(27)] (36) "Restricted network provision" [means], any provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with

the carrier pursuant to [section 354.400, RSMo, et seq.] sections 354.400 to 354.550, RSMo, to provide health care services to covered individuals;

[(28)] (37) "Small employer" [means], in connection with a group health plan with respect to a calendar year and a plan year, any person, firm, corporation, partnership [or], association or political subdivision that is actively engaged in business that[, on at least fifty percent of its working days during the preceding calendar quarter, employed not less than three nor] employed an average of at least two but no more than [twenty-five] fifty eligible employees[, the majority of whom were employed within this state. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state taxation, shall be considered one employer;] on business days during the preceding calendar year and that employs at least two employees on the first day of the plan year. All persons treated as a single employer pursuant to subsection (b), (c), (m) or (o) of Section 414 of the Internal Revenue Code of 1986 shall be treated as one employer. Subsequent to the issuance of a health plan to a small employer and for the purpose of determining continued eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, the provisions of sections 379.930 to 379.952 that

apply to a small employer shall continue to apply at least until the plan anniversary following the date the small employer no longer meets the requirements of this definition. In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of employees that it is reasonably expected that the employer will employ on business days in the current calendar year. Any reference in this act to an employer shall include a reference to any predecessor of such employer;

[(29)**]** (38) "Small employer carrier" **[**means**]**, a carrier that offers health benefit plans covering eligible employees of one or more small employers in this state**[**;

(30) "Standard health benefit plan" means a health benefit plan developed pursuant to section 379.944**]**.

379.938. 1. A health benefit plan subject to sections 379.930 to 379.952 shall be renewable with respect to all eligible employees and dependents, at the option of the small employer, except in any of the following cases:

(1) **[**Nonpayment of the required premiums**]** The plan sponsor fails to pay a premium or contribution in accordance with the terms of a health benefit plan or the health carrier has not received a timely premium payment;

(2) **[**Fraud or misrepresentation of the small employer or,

with respect to coverage of individual insureds, the insureds or their representatives**]** The plan sponsor performs an act or practice that constitutes fraud, or makes an intentional misrepresentation of material fact under the terms of the coverage;

(3) Noncompliance with the carrier's minimum participation requirements;

(4) Noncompliance with the carrier's employer contribution requirements;

(5) **[**Repeated misuse of a provider network provision; or**]** In the case of a small employer carrier that offers coverage through a network plan, there is no longer any enrollee under the health benefit plan who lives, resides or works in the service area of the health insurance issuer;

(6) The small employer carrier discontinues offering a particular type of group health benefit plan in the state's small employer market. A type of health benefit plan may be discontinued by a small employer carrier in such market only if such carrier:

(a) Issues a notice to each plan sponsor and participant provided coverage of such type of the discontinuation at least ninety days prior to the date of discontinuation of the coverage;

(b) Offers to each plan sponsor provided coverage of such type the option to purchase any of the health benefit plans

currently being offered by the small employer carrier in the state's small employer market; and

(c) Acts uniformly without regard to the claims experience of those plan sponsors or any health status-related factor relating to any participant covered or new participant who may become eligible for such coverage;

(7) A small employer carrier may not discontinue offering all health insurance coverage in the small employer market unless:

(a) The carrier provides notice of discontinuation to the director and to each plan sponsor and participant covered at least one hundred eighty days prior to the date of the discontinuation of coverage; and

(b) All health insurance issued or delivered for issuance in Missouri in the small employer market is discontinued and coverage under such health insurance is not renewed;

[(6) The small employer carrier elects to nonrenew all of its health benefit plans delivered or issued for delivery to small employers in this state. In such a case the carrier shall:

(a) Provide advance notice of its decision under this subdivision to the insurance supervisory official in each state in which it is licensed; and

(b) Provide notice of the decision not to renew coverage to all affected small employers and to the insurance supervisory

official in each state in which an affected covered individual is known to reside at least one hundred eighty days prior to the nonrenewal of any health benefit plan by the carrier. Notice to the insurance supervisory official under this paragraph shall be provided at least three working days prior to the notice to the affected small employers;

(7)**]** (8) The director finds that the continuation of the coverage would:

(a) Not be in the best interests of the policyholders or certificate holders; or

(b) Impair the carrier's ability to meet its contractual obligations.

In such instance the director shall assist affected small employers in finding replacement coverage.

2. A small employer carrier that elects not to renew a health benefit plan **[**under**]** pursuant to subdivision **[**(6)**]** (7) of subsection 1 of this section shall be prohibited from writing new business in the small employer market in this state for a period of five years from the date of notice to the director.

3. In the case of a small employer carrier doing business in one established geographic service area of the state, the provisions of this section shall apply only to the carrier's operations in such service area.

4. A small employer carrier offering coverage through a network plan shall not be required to offer coverage or accept applications pursuant to subsection 1 or 2 of this section:

(1) To an eligible person who no longer resides, lives or works in the service area or in an area for which the carrier is authorized to do business, but only if coverage is terminated pursuant to this subdivision uniformly without regard to any health status-related factor of any covered individual; or

(2) To a small employer that no longer has an enrollee in such plan who lives, resides or works in the service area of the carrier or the area for which the carrier is authorized to do business.

5. In the case of health insurance coverage that is made available by a small employer carrier only through one or more bona fide associations, references to "plan sponsor" in this section is deemed, with respect to coverage provided to a small employer member of the association, to include a reference to such employer.

379.940. 1. (1) Every small employer carrier shall, as a condition of transacting business in this state with small employers, actively offer to small employers **[**at least two health benefit plans. One plan offered by each small employer carrier shall be a basic health benefit plan and one plan shall be a standard health benefit plan**]** all health benefit plans it

actively markets to small employers in this state.

(2) (a) A small employer carrier shall issue a [basic health benefit plan or a standard] health benefit plan to any eligible small employer that applies for [either] such plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with sections 379.930 to 379.952.

(b) In the case of a small employer carrier that establishes more than one class of business pursuant to section 379.934, the small employer carrier shall maintain and issue to eligible small employers [at least one basic health benefit plan and at least one standard] all health benefit [plan] plans in each class of business so established. A small employer carrier may apply reasonable criteria in determining whether to accept a small employer into a class of business, provided that:

a. The criteria are not intended to discourage or prevent acceptance of small employers applying for a [basic or standard] health benefit plan;

b. The criteria are not related to the health status or claim experience of the small employer;

c. The criteria are applied consistently to all small employers applying for coverage in the class of business; and

d. The small employer carrier provides for the acceptance of all eligible small employers into one or more classes of

business. The provisions of this paragraph shall not apply to a class of business into which the small employer carrier is no longer enrolling new small employers.

[(3) A small employer is eligible under subdivision (2) of this subsection if it employed at least three or more eligible employees within this state on at least fifty percent of its working days during the preceding calendar quarter.

(4) The provisions of this subsection shall be effective one hundred eighty days after the director's approval of the basic health benefit plan and the standard health benefit plan developed pursuant to section 379.944, provided that if the small employer health reinsurance program created pursuant to sections 379.942 and 379.943 is not yet in operation on such date, the provisions of this subsection shall be effective on the date that such program begins operation.**]**

2. Health benefit plans covering small employers shall comply with the following provisions:

(1) A health benefit plan shall not deny, exclude or limit benefits for a covered individual for losses incurred more than twelve months following the effective date of the individual's coverage due to a preexisting condition. A health benefit plan shall not define a preexisting condition more restrictively than**[**:

(a) a condition that would have caused an ordinarily

prudent person to seek medical advice, diagnosis, care or treatment during the six months immediately preceding the effective date of coverage;

(b)**]** a condition for which medical advice, diagnosis, care or treatment was recommended or received during the six months immediately preceding the effective date of coverage; **[**or

(c)**]** provided, however, that a pregnancy existing on the effective date of coverage shall not be considered a preexisting condition.

(2) A health benefit plan shall waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services for the period of time an individual was previously covered by **[**qualifying previous**]** creditable coverage **[**that provided benefits with respect to such services, provided that the qualifying previous**]**:

(a) The creditable coverage was continuous to a date not less than **[**thirty**]** sixty-three days prior to the **[**effective**]** date of application for the new coverage. **[**This subdivision does not preclude application of any waiting period applicable to all new enrollees under the health benefit plan**]**; and

(b) The aggregate period of such individual's creditable coverage is not less than twelve months.

(3) A health benefit plan may exclude coverage for late enrollees for the greater of eighteen months or provide for an

eighteen-month preexisting condition exclusion, provided that if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period shall not exceed eighteen months from the date the individual enrolls for coverage under the health benefit plan**[**.**]**;

(4) A small employer carrier is prohibited from imposing any preexisting condition exclusion in the following cases:

(a) A small employer carrier shall not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition;

(b) Subject to paragraph (e) of this subdivision, a small employer carrier shall not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the thirty-day period beginning with the date of birth, is covered under creditable coverage;

(c) Subject to paragraph (e) of this subdivision, a small employer carrier shall not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining eighteen years of age and who, as of the last day of the thirty-day period beginning on the date of adoption or placement for adoption, is covered under creditable coverage. The previous sentence shall not apply to coverage before the date of adoption or placement for adoption;

(d) A small employer carrier shall not impose any preexisting condition exclusion in the case of a condition for which medical advice, diagnosis, care or treatment was recommended or received for the first time while the covered person held creditable coverage, and the medical advice, diagnosis, care or treatment was a covered benefit under the plan, provided that the creditable coverage was continuous to a date not more than sixty-three days prior to the enrollment date of the new coverage;

(e) Paragraphs (b) and (c) of this subdivision shall no longer apply to an individual after the end of the first sixty-three-day period during all of which the individual was not covered under any creditable coverage;

[(4)**]** (5) (a) Except as provided in paragraph (d) of this subdivision, requirements used by a small employer carrier in determining whether to provide coverage to a small employer, including requirements for minimum participation of eligible employees and minimum employer contributions, shall be applied uniformly among all small employers with the same number of eligible employees applying for coverage or receiving coverage from the small employer carrier.

(b) A small employer carrier may vary application of minimum participation requirements only by the size of the small employer group.

(c) a. Except as provided in paragraph (b) of this subdivision, in applying minimum participation requirements with respect to a small employer, a small employer carrier shall not consider employees or dependents who have **[**qualifying existing**]** creditable coverage in determining whether the applicable percentage of participation is met.

b. With respect to a small employer with ten or fewer eligible employees, a small employer carrier may consider employees or dependents who have coverage under another health benefit plan sponsored by such small employer in applying minimum participation requirements.

(d) A small employer carrier shall not increase any requirement for minimum employee participation or any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

[(5)**]** (6) (a) If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all of the eligible employees of a small employer and their dependents. A small employer carrier shall not offer coverage to only certain individuals in a small employer group or to only part of the group, except in the case of late enrollees as provided in subdivision (3) of this subsection.

(b) In accordance with the federal Health Insurance

Portability and Accountability Act of 1996, a small employer carrier shall not modify a [basic or standard] health benefit plan with respect to a small employer or any eligible employee or dependent through riders, endorsements or otherwise, to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

3. (1) A small employer carrier shall not be required to offer coverage or accept applications pursuant to subsection 1 of this section in the case of the following:

(a) To a small employer, where the small employer is not physically located in the carrier's established geographic service area;

(b) To an employee, when the employee does not work or reside within the carrier's established geographic service area; or

(c) Within an area where the small employer carrier reasonably anticipates, and demonstrates to the satisfaction of the director, that it will not have the capacity within its established geographic service area to deliver service adequately to the members of such groups because of its obligations to existing group policyholders and enrollees.

(2) A small employer carrier that cannot offer coverage pursuant to paragraph (c) of subdivision (1) of this subsection may not offer coverage in the applicable area to new cases of

employer groups [with more than twenty-five eligible employees] or to any small employer groups until the later of one hundred eighty days following each such refusal or the date on which the carrier notifies the director that it has regained capacity to deliver services to small employer groups.

4. A small employer carrier shall not be required to provide coverage to small employers pursuant to subsection 1 of this section for any period of time for which the director determines that requiring the acceptance of small employers in accordance with the provisions of subsection 1 of this section would place the small employer carrier in a financially impaired condition.

[5. Sections 379.930 to 379.938 and sections 379.942 to 379.950 shall become effective July 1, 1993, this section and section 379.952 shall become effective July 1, 1994.]

379.943. 1. Within one hundred eighty days after the appointment of the initial board, the board shall submit to the director a plan of operation and thereafter any amendments thereto necessary or suitable, to assure the fair, reasonable and equitable administration of the program. The director may, after notice and hearing, approve the plan of operation if the director determines it to be suitable to assure the fair, reasonable and equitable administration of the program, and provides for the sharing of program gains or losses on an equitable and

proportionate basis in accordance with the provisions of sections 379.942 and 379.943. The plan of operation shall become effective upon approval in writing by the director.

2. If the board fails to submit a suitable plan of operation within one hundred eighty days after its appointment, the director shall, after notice and hearing, promulgate and adopt a temporary plan of operation. The director shall amend or rescind any plan so adopted under this subsection at the time a plan of operation is submitted by the board and approved by the director.

3. The plan of operation shall:

(1) Establish procedures for handling and accounting of program assets and moneys and for an annual fiscal report to the director;

(2) Establish procedures for selecting an administering carrier and setting forth the powers and duties of the administering carrier;

(3) Establish procedures for reinsuring risks in accordance with the provisions of sections 379.942 and 379.943;

(4) Establish procedures for collecting assessments from reinsuring carriers to fund claims and administrative expenses incurred or estimated to be incurred by the program; and

(5) Provide for any additional matters necessary for the implementation and administration of the program.

4. The program shall have the general powers and authority granted under the laws of this state to insurance companies and health maintenance organizations licensed to transact business, except the power to issue health benefit plans directly to either groups or individuals. In addition thereto, the program shall have the specific authority to:

(1) Enter into contracts as necessary or proper to carry out the provisions and purposes of sections 379.930 to 379.952, including the authority, with the approval of the director, to enter into contracts with similar programs in other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions;

(2) Sue or be sued, including taking any legal actions necessary or proper to recover any assessments and penalties for, on behalf of, or against the program or any reinsuring carriers;

(3) Take any legal action necessary to avoid the payment of improper claims against the program;

(4) Define the health benefit plans for which reinsurance will be provided, and to issue reinsurance policies, in accordance with the requirements of sections 379.930 to 379.952;

(5) Establish rules, conditions and procedures for reinsuring risks under the program;

(6) Establish actuarial functions as appropriate for the

operation of the program;

(7) Assess carriers in accordance with the provisions of subsection 8 of this section, and to make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses. Any interim assessments shall be credited as offsets against any regular assessments due following the close of the calendar year;

(8) Appoint appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the program, policy and other contract design, and any other function within the authority of the program; and

(9) Borrow money to effect the purposes of the program. Any notes or other evidence of indebtedness of the program not in default shall be legal investments for carriers and may be carried as admitted assets.

5. A small employer carrier participating in the program may reinsure an entire small employer group with the program as provided for in this subsection:

(1) With respect to a basic health benefit plan or a standard health benefit plan, the program shall reinsure the level of coverage provided and, with respect to other plans, the program shall reinsure up to the level of coverage provided in a basic or standard health benefit plan.

(2) A small employer carrier may reinsure an entire small

employer group within sixty days of the commencement of the group's coverage under a health benefit plan or within thirty days after an annual renewal of a small employer group.

(3) (a) The program shall not reimburse a small employer carrier with respect to the claims of an employee or dependent who is part of a reinsured small employer group until the carrier has incurred an initial level of claims for such employee or dependent of five thousand dollars in a calendar year for benefits covered by the program. In addition, the small employer carrier shall be responsible for ten percent of the remaining incurred claims during a calendar year and the program shall reinsure the remainder. A small employer carrier's liability under this paragraph shall not exceed a maximum limit of twenty-five thousand dollars in any one calendar year with respect to any individual who is part of a reinsured small employer group.

(b) The board annually shall adjust the initial level of claims and the maximum limit to be retained by the carrier to reflect increases in costs and utilization within the standard market for health benefit plans within the state. The adjustment shall not be less than the annual change in the medical component of the "Consumer Price Index for All Urban Consumers" of the federal Department of Labor, Bureau of Labor Statistics, unless the board proposes and the director approves a lower adjustment

factor.

(4) A small employer carrier may terminate reinsurance for a small employer on any plan anniversary.

6. (1) The board, as part of the plan of operation, shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals pursuant to sections 379.942 and 379.943. The methodology shall include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer carriers in the state. The methodology shall also include a system for classification of small employer carriers that reflects the degree to which the small employer carrier uses the cost containment features adopted by the health benefit plan committee under section 379.944. The methodology shall provide for the development of base reinsurance premium rates, which shall be multiplied by the factors set forth in subdivision (2) of this act to determine the premium rates for the program. The base reinsurance premium rates, shall be established by the board, subject to the approval of the director, and shall be set at levels which reasonably approximate gross premiums charged to small employers by small employer carriers for health benefit plans with benefits similar to the standard health benefit plan.

(2) Only an entire small employer group may be reinsured,

and the rate for such reinsurance shall be one and one-half times the base reinsurance insurance premium rate for the group established pursuant to this subsection.

(3) The board periodically shall review the methodology established under subdivisions (1) and (2) of this section, including the system of classification and any rating factors, to assure that it reasonably reflects the claims experience of the program. The board may propose changes to the methodology which shall be subject to the approval of the director.

7. If a health benefit plan for a small employer is reinsured with the program, the premium charged to the small employer for any rating period for the coverage issued shall meet the requirements relating to premium rates set forth in section 379.936.

8. (1) Prior to March first of each year, the board shall determine and report to the director the program net loss for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses.

(2) Any net loss for the year shall be recouped by assessments of reinsuring carriers.

(a) The board shall establish, as part of the plan of operation, a formula by which to make assessments against reinsuring carriers and small employer carriers. The assessment

formula shall be based on:

a. The share of each reinsuring carrier which reinsures any small employer group with the program, of the program net loss described in this subsection shall be their proportionate share, determined by premiums earned in the preceding calendar year from health benefit plans which have been ceded to the program, times one-half of the total program net loss;

b. Each reinsuring carrier's share of the program net loss described in this subsection shall be its proportionate share, determined by premiums earned in the preceding calendar year from all health benefit plans delivered or issued for delivery to small employers in this state by all reinsuring carriers, times one-half of the total program net loss. An assessment levied or paid by a reinsuring carrier pursuant to subparagraph a of this paragraph shall not be credited or offset against any assessment levied pursuant to this subparagraph.

(b) The formula established pursuant to paragraph (a) of this subdivision shall not result in any reinsuring carrier having an assessment share that is less than fifty percent nor more than one hundred fifty percent of an amount which is based on the proportion of the small employer carrier's total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by small employer carriers to total premiums earned in the

preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by all small employer carriers.

(c) The director by rule and after a hearing thereon, may change the assessment formula established pursuant to paragraph (a) of this subdivision from time to time as appropriate. The director may provide for the shares of the assessment base attributable to premiums from all health benefit plans and to premiums from health benefit plans ceded to the program to vary during a transition period.

(d) Subject to the approval of the director, the board shall make an adjustment to the assessment formula for reinsuring carriers that are approved health maintenance organizations which are federally qualified under 42 U.S.C.
section 300, et seq., to the extent, if any, that restrictions are placed on them that are not imposed on other small employer carriers.

(e) Premiums and benefits payable by a reinsuring carrier that are less than an amount determined by the board to justify the cost of collection shall not be considered for purposes of determining assessments.

(3) (a) Prior to March first of each year, the board shall determine and file with the director an estimate of the assessments needed to fund the losses incurred by the program in

the previous calendar year.

(b) If the board determines that the assessments needed to fund the losses incurred by the program in the previous calendar year will exceed the amount specified in paragraph (c) of this subdivision, the board shall evaluate the operation of the program and report its findings, including any recommendations for changes to the plan of operation, to the director within ninety days following the end of the calendar year in which the losses were incurred. The evaluation shall include: an estimate of future assessments, the administrative costs of the program, the appropriateness of the premiums charged and the level of insurer retention under the program and the costs of coverage for small employers. If the board fails to file a report with the director within ninety days following the end of the applicable calendar year, the director may evaluate the operations of the program and implement such amendments to the plan of operation the director deems necessary to reduce future losses and assessments.

(c) For any calendar year, the amount specified in this paragraph is five percent of total premiums earned in the previous year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers.

(d) a. If assessments in each of two consecutive calendar years exceed the amount specified in paragraph (c) of subdivision

(3) of this subsection, the program shall be eligible to receive additional financing as provided in subparagraph b of this paragraph.

b. The additional financing provided for in subparagraph a of this paragraph shall be obtained from additional assessments apportioned among all carriers which are not small employer carriers; the amount of the assessment for each carrier determined by the carrier's proportionate share of premiums earned in the preceding calendar year from all health benefit plans delivered, issued for delivery or continued in this state to individuals and groups, other than small employer groups subject to sections 379.930 to 379.952, by all carriers, times the total amount of additional financing to be obtained.

c. The additional assessment provided by subparagraph b of this paragraph shall not exceed an amount equal to one percent of the gross premium derived by that carrier from all health benefit plans delivered, issued for delivery or continued in this state to individuals and groups, other than small employer groups subject to sections 379.930 to 379.952.

d. Any loss sustained by the program which is not reimbursed by additional financing obtained pursuant to this paragraph shall be carried forward to the calendar year succeeding the year in which the loss is sustained, and shall be recouped by an increase in premiums charged by the board for

reinsurance of small employer groups with the program.

e. Additional financing received by the program pursuant to this paragraph shall be distributed to reinsuring carriers in proportion to the assessments paid by such carriers over the previous two calendar years.

(4) If assessments exceed net losses of the program, the excess shall be held at interest and used by the board to offset future losses or to reduce program premiums. As used in this paragraph, "future losses" includes reserves for incurred but not reported claims.

(5) Each carrier's proportion of the assessment shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed by the carriers with the board.

(6) The plan of operation shall provide for the imposition of an interest penalty for late payment of assessments.

(7) A carrier may seek from the director a deferment from all or part of an assessment imposed by the board. The director may defer all or part of the assessment of a carrier if the director determines that the payment of the assessment would place the carrier in a financially impaired condition. If all or part of an assessment against a carrier is deferred, the amount deferred shall be assessed against the other participating carriers in a manner consistent with the basis for assessment set

forth in this subsection. The carrier receiving such deferment shall remain liable to the program for the amount deferred and the interest penalty provided in subdivision (6) of this subsection and shall be prohibited from reinsuring any groups in the program until such time as it pays such assessments.

9. Neither the participation in the program as reinsuring carriers, the establishment of rates, forms or procedures, nor any other joint or collective action required by sections 379.930 to 379.952 shall be the basis of any legal action, criminal or civil liability, or penalty against the program or any of its reinsuring carriers either jointly or separately, other than any action by the director to enforce the provisions of sections 379.930 to 379.952.

10. The board, as part of the plan of operation, shall develop standards setting forth the manner and levels of compensation to be paid to producers for the sale of basic and standard health benefit plans. In establishing such standards, the board shall take into the consideration: the need to assure the broad availability of coverages; the objectives of the program; the time and effort expended in placing the coverage; the need to provide ongoing service to the small employer; the levels of compensation currently used in the industry; and the overall costs of coverage to small employers selecting these plans.

11. The program shall be exempt from any and all taxes.

12. The director shall make an initial assessment of one thousand dollars on each insurance company authorized to transact accident or health insurance, each health services corporation, and each health maintenance organization. Initial assessments shall be made during January, 1993, and shall be paid before April 1, 1993. Initial assessments shall be deposited into the department of insurance dedicated fund. Within ten days after the effective date of the program's plan of operation, the total amount of the initial assessments shall be transferred at the request of the director to the Missouri small employer health reinsurance program. The program may use such initial assessment in the same manner and for the same purposes as other assessments pursuant to sections 379.942 and 379.943.

13. The program shall not accept any new risks or renew any existing risk on or after October 1, 2004.

14. Any program assets or moneys that exceed six hundred thousand dollars on August 28, 2004, shall be delivered on October 1, 2004, to the Missouri health insurance pool as established in sections 376.960 to 376.989, and shall be accepted by the Missouri health insurance pool and used for the administration and operation of the Missouri health insurance pool.

15. Any program assets or moneys that remain on October 1,

2005, shall be delivered on October 31, 2005, to the Missouri health insurance pool as established in sections 376.960 to 376.989, and shall be accepted by the Missouri health insurance pool and used for the administration and operation of the Missouri health insurance pool.

16. The provisions of this section shall expire on December 31, 2005.

379.952. 1. Each small employer carrier shall actively market health benefit plan coverage, including the basic and standard health benefit plans, to eligible small employers in the state. **[**If a small employer carrier denies coverage to a small employer on the basis of the health status or claims experience of the small employer or its employees or dependents, the small employer carrier shall offer the small employer the opportunity to purchase a basic health benefit plan or a standard health benefit plan.**]**

2. (1) Except as provided in subdivision (2) of this subsection, no small employer carrier or agent or broker shall, directly or indirectly, engage in the following activities:

(a) Encouraging or directing small employers to refrain from filing an application for coverage with the small employer carrier because of the health status, claims experience, industry, occupation or geographic location of the small employer;

(b) Encouraging or directing small employers to seek coverage from another carrier because of the health status, claims experience, industry, occupation or geographic location of the small employer.

(2) The provisions of subdivision (1) of this subsection shall not apply with respect to information provided by a small employer carrier or agent or broker to a small employer regarding the established geographic service area or a restricted network provision of a small employer carrier.

3. (1) Except as provided in subdivision (2) of this subsection, no small employer carrier shall, directly or indirectly, enter into any contract, agreement or arrangement with an agent or broker that provides for or results in the compensation paid to an agent or broker for the sale of a health benefit plan to be varied because of the health status, claims experience, industry, occupation or geographic location of the small employer.

(2) Subdivision (1) of this subsection shall not apply with respect to a compensation arrangement that provides compensation to an agent or broker on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation or geographic area of the small employer.

4. A small employer carrier shall provide reasonable

compensation, as provided under the plan of operation of the program, to an agent or broker, if any, for the sale of a basic or standard health benefit plan.

5. No small employer carrier shall terminate, fail to renew or limit its contract or agreement of representation with an agent or broker for any reason related to the health status, claims experience, occupation, or geographic location of the small employers placed by the agent or broker with the small employer carrier.

6. No small employer carrier or producer shall induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment.

7. Denial by a small employer carrier of an application for coverage from a small employer shall be in writing and shall state the reason or reasons for the denial with specificity.

8. The director may promulgate rules setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to small employers in this state.

9. (1) A violation of this section by a small employer carrier or a producer shall be an unfair trade practice **[**under**]** pursuant to sections 375.930 to 375.949, RSMo.

(2) If a small employer carrier enters into a contract,

agreement or other arrangement with a third-party administrator to provide administrative marketing or other services related to the offering of health benefit plans to small employers in this state, the third-party administrator shall be subject to this section as if it were a small employer carrier.

10. For purposes of health benefit plans sold to employers of exactly two eligible employees and health benefit plans sold to employers with more than twenty-five eligible employees but not more than fifty eligible employees, sections 379.930 and 379.936 shall become effective July 1, 2005.

382.210. 1. No insurer subject to registration under section 382.100 shall pay any extraordinary dividend or make any other extraordinary distribution to its shareholders until thirty days after the director has received notice of the declaration thereof and has not within such period disapproved such payment, or the director has approved the payment within such thirty-day period. For purposes of this section, an extraordinary dividend or distribution includes any dividend or distribution of cash or other property, whose fair market value together with that of dividends or distributions made within the period of twelve consecutive months ending on the date on which the proposed dividends are scheduled for payment or distribution**[**:

(1) For life insurance companies and title insurance companies, such amount**]** exceeds the greater of ten percent of the

insurer's surplus as regards policyholders as of the thirty-first day of December next preceding, or the net gain from operations of the insurer, if the insurer is a life insurer, or the net investment income, if the insurer is a title insurer, or net income if the insurer is other than a life or title insurer, for the twelve-month period ending the thirty-first day of December next preceding, but shall not include pro rata distributions of any class of the insurer's own securities**[**;

(2) For all other insurers, such amount exceeds the lesser of ten percent of the insurer's surplus as regards policyholders as of the thirty-first day of December next preceding, or the net investment income for the twelve-month period ending the thirty-first day of December next preceding, but shall not include pro rata distributions of any class of the insurer's own securities**]**.

2. **[**A life or title insurer**]** Insurers subject to registration under section 382.100 may only pay a shareholder dividend from earned surplus. With the prior approval of the director, a dividend may be declared from other than earned surplus.

3. No **[**life or title**]** insurer subject to registration under section 382.100 shall pay any extraordinary dividend unless, after the transaction is completed, the company's surplus as regards policyholders is reasonable in relation to the company's

outstanding liabilities and adequate to its financial needs. In making this determination, the director shall use the factors found in section 382.200 and may consider:

(1) The quality of the company's earnings and the extent to which the reported earnings include extraordinary items; or

(2) The recent past and projected future trend in the company's surplus as regards policyholders.

4. Notwithstanding any other provision of law, an insurer may declare an extraordinary dividend or distribution which is conditional upon the director's approval thereof, and the declaration shall confer no rights upon shareholders until the director has approved the payment of the dividend or distribution, or the director has not disapproved the payment within the thirty-day period referred to above.

384.043. 1. No **[**agent or broker**]** insurance producer shall procure any contract of surplus lines insurance with any nonadmitted insurer, unless he possesses a current surplus lines insurance license issued by the director.

2. The director shall issue a surplus lines license to any qualified holder of a current resident or nonresident property and casualty insurance producer license but only when the licensee has:

(1) Remitted the one hundred dollar initial fee to the director;

(2) Submitted a completed license application on a form supplied by the director; and

(3) Passed a qualifying examination approved by the director, except that all holders of a license prior to July 1, 1987, shall be deemed to have passed such an examination**[**; and

(4) Filed with the director, and maintains during the term of the license, in force and unimpaired, a bond in favor of this state in the penal sum of one hundred thousand dollars or in a sum equal to the tax liability for the previous tax year, whichever is smaller, aggregate liability, with corporate sureties approved by the director. The bond shall be conditioned that the surplus lines licensee will conduct business in accordance with the provisions of sections 384.011 to 384.071 and will promptly remit the taxes as provided by law. No bond shall be terminated unless at least thirty days' prior written notice is given to the licensee and director**]**.

3. Each surplus lines license shall be renewed annually on the anniversary date of issuance and continue in effect until refused, revoked or suspended by the director in accordance with section 384.065; except that if the annual renewal fee for the license is not paid on or before the anniversary date, the license terminates. The annual renewal fee is fifty dollars.

384.062. 1. If the tax collectible by a surplus lines licensee under the provisions of sections 384.011 to 384.071 has

been collected and is not paid within the time prescribed, the same shall be recoverable in a suit brought by the director against the surplus lines licensee **[**and the surety on the bond filed under section 384.043**]**.

2. All taxes, penalties, and interest or delinquent taxes levied pursuant to this chapter shall be paid to the director, who shall obtain such taxes, penalties and interest by civil action against the insured or the surplus lines licensee **[**and his bond**]**, and the director shall remit such taxes when collected to the director of revenue. All checks and drafts remitted for the payment of such taxes, penalties and interest shall be made payable to the director of revenue.

3. Taxes collected pursuant to this chapter are taxes collected by the director of revenue within the meaning of section 139.031, RSMo.

384.065. The director may suspend, revoke, or refuse to renew the license of a surplus lines licensee after notice and hearing as provided under the applicable provisions of this state's laws upon any one or more of the following grounds:

(1) Removal of the resident surplus lines licensee's office from this state;

(2) Removal of the resident surplus lines licensee's office accounts and records from this state during the period during which such accounts and records are required to be maintained

under section 384.059;

(3) Closing of the surplus lines licensee's office for a period of more than thirty business days, unless permission is granted by the director;

(4) Failure to make and file required reports;

(5) Failure to transmit required tax on surplus lines premiums;

(6) **[**Failure to maintain required bond;

(7)**]** Violation of any provision of **[**this act**]** sections 384.011 to 384.071; or

[(8)**]** (7) For any cause for which an insurance license could be denied, revoked, suspended or renewal refused under section 375.141, RSMo.

[379.942. 1. There is hereby created a nonprofit entity to be known as the "Missouri Small Employer Health Reinsurance Program". All small employer carriers shall participate in the program as reinsuring carriers for a minimum of three years beginning July 1, 1993. After the expiration of such three years, a small employer carrier may apply to the director to opt out of the program. The director shall decide whether to grant such an application to opt out, and shall consider in making such determination only: the carrier's financial condition and the financial condition of its guaranteeing or reinsuring corporation, if any; its history of assuming and managing risk; its ability to assume and manage the risk of enrolling small employers without the protection of the program; and its commitment to market fairly to all small employers in its service area. If the director grants such application, the small employer carrier shall participate in

the program neither as a ceding nor reinsuring carrier.

2. (1) The program shall operate subject to the supervision and control of the board. Subject to the provisions of subdivision (2) of this subsection, the board shall consist of nine members appointed by the director plus the director or his designated representative, who shall serve as an ex officio member of the board.

(2) (a) In selecting the members of the board, the director shall include representatives of small employers, small employer employees or their representatives and small employer carriers and such other individuals determined to be qualified by the director. At least five of the members of the board shall be representatives of reinsuring carriers and at least one of the members of the board shall be a representative of a health maintenance organization which is a small employer carrier. All members shall be selected from individuals nominated by small employer carriers in this state pursuant to procedures and guidelines developed by the director, except that the director shall select two small employers' employees, including at least one representative of a labor organization.

(b) In the event that the program becomes eligible for additional financing pursuant to subdivision (3) of subsection 8 of section 379.943, the board shall be expanded to include two additional members who shall be appointed by the director. In selecting the additional members of the board, the director shall choose individuals who represent reinsuring carriers. The expansion of the board under this paragraph shall continue for the period that the program continues to be eligible for additional financing under subdivision (3) of subsection 8 of section 379.943.

(3) The initial board members shall be appointed as follows: one-third of the members to serve a term of two years; one-third of the members to serve a term of

four years; and one-third of the members to serve a term of six years. Subsequent board members shall serve for a term of three years. A board member's term shall continue until his successor is appointed.

(4) A vacancy in the board shall be filled by the director. A board member may be removed by the director for cause.

3. Within sixty days of July 1, 1993, each small employer carrier shall make a filing with the director containing the carrier's net health insurance premium derived from health benefit plans delivered or issued for delivery to small employers in this state in the previous calendar year.**]**

Section B. The repeal of section 379.942 of section A of this act shall become effective December 31, 2005.